

**BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA**

In the Matter of the Third Amended )  
Accusation Against: )  
 )  
**IFEATU E. EKELEM, M.D.** )  
 )  
Physician's and Surgeon's )  
Certificate No. A43177 )  
 )  
Petitioner )  
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Case No. 08-2010-205606

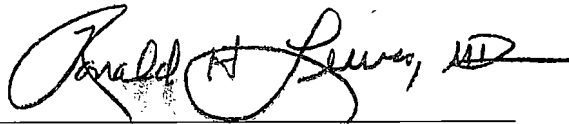
OAH No. 2012100045

**ORDER DENYING PETITION FOR RECONSIDERATION**

The Petition filed by IFEATU E. EKELEM, M.D. for the reconsideration of the decision in the above-entitled matter, having been read and considered by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on March 29, 2018.

**IT IS SO ORDERED: March 29, 2018.**



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Ronald H. Lewis, M.D., Chair  
Panel A

**BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA**

In the Matter of the Third Amended Accusation )  
Against: )  
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IFEATU EKELEM, M.D. )  
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Respondent. )

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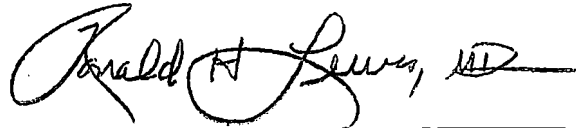
**ORDER CORRECTING NUNC PRO TUNC  
CAPTION IN DECISION**

On its own motion, the Medical Board of California (hereafter "board") finds that there is a clerical error reflecting the title of the caption in the Decision in the above-entitled matter, and that such clerical error should be corrected.

IT IS HEREBY ORDERED that the caption in the Decision in the above-entitled matter be and is hereby amended and corrected nunc pro tunc to read as follows:

"In the Matter of the Third Amended Accusation Against: Ifeatu Ekelem, M.D., Physician's and Surgeon's Certificate No. A43177, Respondent."

IT IS SO ORDERED March 13, 2018.



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Ronald H. Lewis, M.D., Chair  
Panel A  
Medical Board of California

**BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA**

**In the Matter of the Accusation )  
Against: )**

**IFEATU EKELEM, M.D. )**

**Case No. 08-2010-205606**

**Physician's and Surgeon's )  
Certificate No. A43177 )**

**Respondent )  
\_\_\_\_\_ )**

**DECISION**

**The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.**

**This Decision shall become effective at 5:00 p.m. on March 29, 2018.**

**IT IS SO ORDERED February 27, 2018.**

**MEDICAL BOARD OF CALIFORNIA**

**By: \_\_\_\_\_**

**Ronald H. Lewis, M.D., Chair  
Panel A**

BEFORE THE  
MEDICAL BOARD OF CALIFORNIA  
DEPARTMENT OF CONSUMER AFFAIRS  
STATE OF CALIFORNIA

In the Matter of the Third Amended  
Accusation Against:

IFEATU EKELEM, M.D.,

Physician's and Surgeon's Certificate  
Number A 43177

Respondent.

Case No. 08-2010-205606

OAH No. 2012100045

**PROPOSED DECISION**

Administrative Law Judge Coren D. Wong, Office of Administrative Hearings, State of California, heard this matter on February 8 through 12, 2016; March 21 through 24 and 28 through 30, 2016; April 4 and 5, 2016; January 23 through 27, 2017; and September 18 through 22, 2017, in Fresno, California.

Deputies Attorney-General Mia Perez-Arroyo and Vladimir Shalkevich represented complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board).<sup>1</sup>

Attorney Steven R. Stoker of the law firm Pascuzzi Moore & Stoker represented respondent Ifeatu Ekelem, M.D., through April 5, 2017, after which Dr. Ekelem was a self-represented litigant. Dr. Ekelem was present throughout the hearing.

Evidence was received, and the record was left open to receive the parties' simultaneous closing briefs. Neither party submitted his or her closing brief by the deadline imposed, and the record was reopened to receive their briefs. Complainant's Closing

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<sup>1</sup> Ms. Perez-Arroyo initially represented complainant, but on September 15, 2016, this matter was re-assigned to Mr. Shalkevich.

Argument is marked as Exhibit 77, and Respondent's Closing Statement is marked as Exhibit P. The record was closed and the matter was submitted for decision on December 14, 2017.<sup>2</sup>

## SUMMARY

Complainant seeks to discipline respondent's physician's and surgeon's certificate based on allegations arising out of the treatment and care 14 patients received at Impact Medical Group, a corporation of which respondent was the sole shareholder at all relevant times and which did business as 24/7 Urgent Care Clinic. Cause for discipline exists. When all relevant evidence is considered, respondent did not introduce sufficient evidence of his continued ability to perform the duties of a physician and surgeon in a manner consistent with public health, safety, and welfare, even under a probationary license. Therefore, his physician's and surgeon's certificate is revoked.

## FACTUAL FINDINGS

### *Procedural Background*

1. On October 6, 1986, the Board issued Physician's and Surgeon's Certificate Number A 43177 to respondent. The certificate expires June 16, 2018, unless renewed or revoked. There is no history of prior discipline of the certificate.

2. Complainant caused the Third Amended Accusation to be filed on March 1, 2017, solely in her official capacity.<sup>3</sup> The Third Amended Accusation seeks to discipline respondent's certificate based on allegations that the treatment and care 14 patients received at 24/7 Urgent Care Clinic violated the Medical Practice Act (Bus. & Prof. Code, § 2000 et seq.).

### *Respondent's Background*

3. Respondent was born in the City of Warri, an oil hub in the southern part of Nigeria. He attended Modebe Memorial Grammar School in Onitsha, Nigeria, and received his high school diploma in 1971. He then attended advanced high school at Dennis Memorial Grammar School, and earned a degree in physics, biology, and chemistry in 1974.

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<sup>2</sup> On December 21, 2017, the Office of Administrative Hearings received a copy of Respondent's Closing Statement, which respondent characterized as an "addendum." The addendum was filed without leave of the administrative law judge, is stricken from the record, and was not considered.

<sup>3</sup> Complainant's predecessor caused the original accusation to be filed on August 20, 2012.

4. Respondent attended the University of Ibadan College of Medicine, a five-year medical program in Ibadan, Nigeria. The first two years of the program were spent in the classroom learning background sciences, and the last three years were spent performing clinical rotations in areas such as obstetrics, gynecology, surgery, pediatrics, and internal medicine at the teaching hospital affiliated with the medical school. Respondent obtained his medical degree in June 1979.

5. Respondent completed a one-year internship at the teaching hospital affiliated with Ahmadu Bello University in Zaria, Nigeria, in June 1980. The internship was a "rotating internship," which meant he spent three months in each of the areas of pediatrics, internal medicine, surgery, and obstetrics/gynecology.

6. Nigeria requires all of its college graduates to take part in its National Youth Service Corps Program for one year prior to obtaining employment in their field of study. The program is a national service program that requires participants to contribute to the development of Nigeria by serving in the areas of government, education, or agriculture. Participants are sent to cities far from the one from which they originate in order to expose them to different social, familial, and cultural backgrounds, and to encourage unity and appreciation amongst the different ethnic groups living throughout Nigeria.

7. Respondent completed his commitment to the National Youth Service Corps Program by working for Nigeria's Ministry of Defense, the governmental agency in charge of the three branches of Nigeria's military. He was assigned to the Obstetrics/Gynecology Department at the Yaba Military Hospital in Lagos, Nigeria, for nearly two and one-half years. He described his experience as "almost like a specialization."

8. The National Youth Service Corps Program pays participants only a minimal salary. For extra income, respondent also worked at St. Theresa's Hospital for Women in Apaga, Nigeria. He worked closely with the gynecologist who ran the hospital, and did "anything that has to do with women [*sic*] including abortions. Tons of abortions."

9. After completing his obligation to the National Youth Service Corps Program, respondent obtained a student visa and enrolled in the Masters of Science in Public Health program at Howard University in Washington, D.C. After obtaining his degree, he completed a medical internship in pediatrics at Meharry Medical College in Nashville, Tennessee. In June 1987, he completed a two-year medical residency in pediatrics at King/Drew Medical Center in Los Angeles, California. He then completed a two-year joint fellowship in neonatology at King/Drew Medical Center and Harbor UCLA Medical Center.

10. Respondent was board-certified in pediatrics by The American Board of Pediatrics from 1990 through 1997. He renewed his board-certification in 1998. Respondent was also board-certified in the sub-specialty of neonatology/perinatology from 1991 through 1998. He was not board-certified in any medical specialty or sub-specialty at all times relevant to the Third Amended Accusation.

11. In June 1991, respondent began his career as a physician in the United States as an Assistant Clinical Professor of Neonatology at the University of California, Irvine, in Irvine, California. He obtained his Tennessee medical license on May 25, 1993, and began working the following month as an Assistant Professor and the Director of the Division of Neonatology at Meharry Medical College and Nashville General Hospital in Nashville, Tennessee.

12. Respondent was the attending neonatologist at The Medical Center in Jackson, Tennessee, from August 1995 through June 1997. He then became the medical director at Pediatrics 24, an urgent care located in Jackson, Tennessee, where he remained until October 2004.

13. Respondent returned to California and became the medical director at Kings Canyon Winery Medical Clinic in Fresno, California, in October 2004. Two years later, he also began working at Pediatric Urgent Care. In September 2007, he became the medical director at WestCare, another urgent care in Fresno.

14. Respondent incorporated Impact Medical Group in 2006 and began doing business under the fictitious name "24/7 Urgent Care Clinic," an urgent care located on Kings Canyon Road in Fresno. Two years later, he opened a second location on Herndon Street in Fresno.

15. Respondent served as the Medical Director at 24/7 Urgent Care Clinic until he sold his interest in the business in April 2017. He frequently traveled out of the country while serving as medical director, and hired physicians on a temporary basis to serve during his absence.

#### *The Board's Investigation of Respondent and 24/7 Urgent Care Clinic*

16. Between March 9, 2010, and December 22, 2014, the Board's Central Complaint Unit received consumer complaints from or on behalf of SC, LV, SG, DN, AJ, WL, LS, MH, HR, SMG, MT, VR, and BH, patients who received treatment and care from 24/7 Urgent Care Clinic between January 1, 2010, and September 5, 2014. Each complaint was assigned to Board investigator Patricia Sanchez-Bartunek for investigation. During her investigation, Ms. Sanchez-Bartunek was contacted by DM, a patient who received treatment and care from 24/7 Urgent Care Clinic on September 20, 2009.

17. Ms. Sanchez-Bartunek interviewed SC, SG's mother, DN and his wife, AJ, WL, LS, MH, HR's daughter, SMG, VR, and BH as part of her investigation, and documented those interviews in numerous investigation reports. The relevant substance of each of those interviews is incorporated below into the discussion of the treatment and care

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each patient received, to the extent it constituted admissible evidence.<sup>4</sup> Additionally, SG's mother, DN and his wife, LS, HR's daughter, and MT testified at hearing, and the relevant testimony is also incorporated into the discussion below.

18. Ms. Sanchez-Bartunek interviewed respondent on January 7, 2014. He was asked whether his Tennessee medical license has ever been disciplined, and he explained the license expired in 2003 and was not renewed "because I did not show up for the interview to renew my license and clarify some of the quest - answers that I gave them, honestly gave them in the form that I filled out." But the Tennessee Board of Medical Examiners explained in a September 29, 2004 correspondence to respondent:

The Tennessee Board of Medical Examiners met on September 21, 2004 [*sic*] at their regularly scheduled meeting. You were notified that you were scheduled for an interview pertaining to your application for reinstatement of your license to practice medicine in Tennessee. You did not appear as requested. The Board's decision was to deny your reinstatement application at this time. The denial is based on your conduct in relation to hospital privileges and the balance billing conduct regarding Blue Cross and Blue Shield [*sic*] both of which are grounds for denial of your application pursuant to T.C.A. §§ 63-6-214 (b) (1) and (3) which state s [*sic*] that the Board has the authority to deny licensure on any of the following grounds:

- (1) Unprofessional, dishonorable or unethical conduct; and
- (3) Making false statements or representations, being guilty of fraud or deceit in obtaining admission to practice, or being guilty of fraud or deceit in the practice of medicine.

19. Other relevant portions of respondent's January 7, 2014 interview, as well as the two subsequent interviews, are incorporated below.

20. Ms. Sanchez-Bartunek interviewed Michelle Altman-Anderson, who also testified at hearing. Ms. Altman-Anderson told Ms. Sanchez Bartunek she worked for 24/7 Urgent Care Clinic for about one month in April and May 2010. At hearing, however, Ms. Altman-Anderson explained she was laid off after working for two months. She was

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<sup>4</sup> The investigation reports were admitted into evidence pursuant to the California Supreme Court's ruling in *Lake v. Reed* (1997) 16 Cal.4th 448, 461-462 [a party's statement documented in a police report may be considered for all purposes as a party admission, whereas third-party witness statements documented in the report may be considered only as administrative hearsay pursuant to Evid. Code, § 11513, subd. (d)].

responsible for patient billing for both the Kings Canyon Road and the Herndon Street locations.

21. Ms. Altman-Anderson told Ms. Sanchez-Bartunek she and other staff were instructed to charge all patients a co-payment of \$50. If a patient questioned that amount, staff was supposed to explain that the patient would receive a refund of any overpayment if his or her health insurance paid 24/7 Urgent Care Clinic's claim. Ms. Altman-Anderson kept a ledger of each patient owed a refund, but explained no refunds were issued while she worked at 24/7 Urgent Care Clinic.

22. Ms. Altman-Anderson also told Ms. Sanchez-Bartunek respondent's common diagnosis was dehydration, and he liked to order IV fluids as well as the antibiotic Rocephin. The wholesale cost of Rocephin was \$.50 per unit, for which 24/7 Urgent Care Clinic charged \$99.

23. Finally, Ms. Altman-Anderson told Ms. Sanchez Bartunek respondent would ask patients how much they could pay, and then charged them accordingly. She claimed to have seen him complete IV logs for patients after they left 24/7 Urgent Care Clinic. She also claimed to have seen medical assistants pull patients' charts after the patients' insurance companies denied 24/7 Urgent Care Clinic's claim for services, and respondent change the notes on the medical charts to address the reasons for which the claims were denied.

24. At hearing, Ms. Altman-Anderson testified every patient who had health insurance was required to pay a \$50 co-payment, regardless of the amount listed on his or her insurance card. If a patient refused to pay that amount, he or she was not seen. She also testified patients were "rarely" refunded any overpayments after their insurance paid 24/7 Urgent Care Clinic's claim. But she also testified respondent issued refunds to patients while she worked at 24/7 Urgent Care Clinic. She also stated Exhibit 8 contains the office policies in effect during her employment. One of those policies provides:

Ask for \$50 urgent care co-pay (if not otherwise stated on insurance card) or office visit fee if no insurance. If patient insists they don't have co-pay or that it is less, don't argue with them, just make note of it on chart. (Remember to first tell them why it's more because it's urgent care)

25. Cecilia Borbon was also interviewed by Ms. Sanchez-Bartunek and testified at hearing. As of the date of hearing, she has worked in the billing and collections department of 24/7 Urgent Care Clinic since October 2009. She explained the procedure for collecting co-payments during her employment has always been to collect the amount listed on the patient's insurance card. If no amount is listed, the patient is asked the amount of his or her co-payment and that amount is collected. If the patient does not know the amount of his or her co-payment, nothing is collected and the patient is sent a bill.

*Treatment and Care Provided to Patients at 24/7 Urgent Care Clinic*

PATIENT SC

26. SC was a 63-year-old female who presented to 24/7 Urgent Care Clinic on January 1, 2010, with symptoms of diarrhea and vomiting for several days, with the diarrhea worsening and progressing to bleeding from the rectum. She also complained of pain in her abdomen and a headache.

27. Respondent examined SC, and documented her chief complaint on her medical chart as "nausea, vomiting, diarrhea since Monday, today no vomiting, since last night rectal bleeding." He documented his findings upon physical examination by writing "bloody anus" and "abdomen — mild discomfort on palpation." He did not document having performed a rectal examination or ordered a stool sample, and he admitted he did neither during a subsequent interview by Ms. Sanchez-Bartunek. He recorded SC's current medications as "see list," and then attached documentation she provided which included her medical history, medications, and allergies. She had a past history of diverticulitis in 2008.

28. Respondent diagnosed SC with "severe/moderate dehydration secondary to [acute gastroenteritis]/dysentery." His treatment included three liters of normal saline intravenously over approximately a three-hour period, and providing two grams of Rocephin intravenously. The medical chart does not contain the signature or initials of the person who administered the Rocephin. Nor does it contain respondent's signature or initials for the entries he made. His discharge instructions were to follow up at CVS on Herndon/Melbourne to fill the prescriptions he provided.

29. A different copy of SC's medical chart indicates her chief complaint was "bloody stools x 3 days." It also contains a more detailed description of respondent's findings after physical examination, including "cold clammy, mildly febrile, moderately dehydrated, mild sunken eyes, chest clear clinically." This copy also documents with a different pen that a fourth liter of normal saline was administered to SC. Respondent's discharge instructions were to "follow up with PCP ASAP for possible stool culture, chem panel, fluid advice, if get worse — rush to ER."

30. Respondent did not complete an IV log for SC, despite his insistence during an interview by Ms. Sanchez-Bartunek that one is prepared for every patient who receives an IV. An IV log is an internal document on which the start time and end time for the IV is documented, as well as the patient's vital signs at 15-minute intervals throughout the administration of the IV.

31. SC was given four liters of normal saline by hanging four consecutive one-liter bags. Respondent did not reassess the patient after each liter of saline to determine how well she was responding to the fluids and whether she needed more.

32. Neither SC nor her daughter testified at a hearing. Therefore, there was no admissible evidence to support the allegations that respondent or someone at 24/7 Urgent Care Clinic misrepresented respondent's medical credentials to SC or her daughter.

33. Prior to visiting 24/7 Urgent Care Clinic on January 1, 2010, SC called to confirm that respondent was an approved provider under her health insurance, which was Blue Shield of California CalPERS Access+ at the time. After receiving assurances that he was, she presented for treatment.

34. When SC arrived at 24/7 Urgent Care Clinic, she paid the \$50 co-payment listed on her insurance card for "Emergency." The receipt is time-stamped "13:35:11." She was not told there may be additional charges, depending on the treatment and services ultimately provided.

35. After receiving treatment, SC was given a bill in the amount of \$3,200 for four bags of normal saline, and was told her insurance would pay 80 percent of the bill and the remaining 20 percent (\$640) was her responsibility. She responded by explaining her insurance was an HMO plan, and she was not required to pay anything other than a co-payment. Staff insisted she pay \$640, and she did so. The receipt is time-stamped "16:25:39."

36. Respondent was not an approved provider under the Blue Shield of California CalPERS Access+ health plan when he treated SC on January 1, 2010. Therefore, he was not bound by any agreement between Blue Shield of California and its approved providers regarding rates of reimbursement for treatment and services provided its members. And while he ultimately refunded the \$640 to SC on July 29, 2011, there was no admissible evidence of the reason for the refund or that Blue Shield of California paid respondent anything for the treatment and services provided SC.

#### PATIENT LV

37. LV was a 32-year-old female who presented to 24/7 Urgent Care Clinic on July 8, 2010, with flu symptoms for more than 24 hours, including fever, cough, sinus congestion, headache, body aches. Respondent examined the patient, and documented her chief complaint on the medical chart as "flu symptoms." He did not document her past medical history. For physical examination, he documented all vital signs, except respiratory rate, and wrote "ill, not in distress, rales/rhonchi, heart regular rate and rhythm no murmur, HEENT: sinus tender." He did not order a chest x-ray, later explaining he did not want to expose the patient to radiation unnecessarily.

38. Respondent diagnosed LV with pneumonitis and sinusitis, and ordered that one gram of the antibiotic Rocephin be given intramuscularly to treat any bacterial infection that may have been causing her tender sinuses. He also ordered that 40 milligrams of the corticosteroid Kenalog be given intramuscularly to treat the inflammation in the patient's sinuses and lungs. Those two shots were administered, but the medical chart does not

indicate by whom. The Kenalog shot was injected into LV's subcutaneous fat, instead of her muscle, and she developed lipodystrophy (a fat abnormality visible as a dent) at the injection site.

39. Respondent gave LV written prescriptions for Prednisone, 40 milligrams a day for five days, a Z-Pak Pro Air Inhaler, and Allegra D. His written discharge instructions were "must follow-up with primary care physician as soon as possible."

40. During an interview with Ms. Sanchez-Bartunek, respondent explained Prednisone is a corticosteroid used as an anti-inflammatory, similar to Kenalog. He further explained either he or a medical assistant administers medications he orders for patients, but he had no recollection who administered the Rocephin and Kenalog to LV.

#### PATIENT SG

41. SG was a four-year-old boy whose mother brought him to 24/7 Urgent Care Clinic on September 5, 2010, at approximately 1:15 p.m., with symptoms of vomiting, dehydration, weakness, and labored breathing. The receptionist told SG's mother she owed a \$50 co-payment under her insurance plan, which was the Blue Cross Prudent Buyer. The mother explained she called the insurance company prior to coming to 24/7 Urgent Care Clinic to confirm respondent was an authorized provider under her plan, was told he was, and was told she would be required to pay only a \$15 co-payment. The receptionist insisted on collecting \$50, and SG's mother relented.

42. Respondent examined the patient, and documented the chief complaint on the medical chart as "multiple episodes of vomiting x 12 in day; now tired, not moving or responding as well. Also seems to be breathing hard. No diarrhea. No fever." No past medical history is documented on the chart.

43. Under physical exam, respondent documented all of SG's vital signs, except respiratory rate, and wrote "ill, moderately dehydrated child, sunken eyes, decreased skin turgor, tachypnea, chest clear clinically, heart regular rate and rhythm with no murmur; abdomen flat, soft, non-tender; extremities, full range of motion." Under the portion of the chart labeled "S," respondent wrote the patient "seems to be breathing hard" and was "not moving or responding well." He did not document the patient's level of alertness.

44. Respondent did not order a chest x-ray. He diagnosed SG with "moderate dehydration due to acute gastroenteritis." He ordered the administration of fluids intravenously, which a medical assistant started at approximately 1:50 p.m. Approximately one hour later, the medical assistant returned and administered 12.5 milligrams of Phenergan, intramuscularly, ordered by respondent. The medication caused SG to suffer an allergic reaction, and his mother ran out of the examination room to the reception desk for help. Respondent returned to the examination room and ordered a third liter of fluids, which the medical assistant began at approximately 3:50 p.m.

45. 24/7 Urgent Care Clinic's preprinted IV log contains spaces to indicate the time an IV was started; the patient's temperature, blood pressure, pulse rate, and oxygen saturation rate at 15 minute intervals throughout the administration of the IV; and the time each set of vital signs was taken. The IV log for SG indicates the IV was started at 2:00 p.m., but the initial set of vital signs was not taken until 2:09 p.m. and did not include his blood pressure. The second set of vital signs was taken at 2:44 p.m., and also did not include SG's blood pressure. No subsequent vital signs were documented on the IV log, although the time of 3:00 p.m. was written for the 30-minute interval set of vital signs.

46. At hearing, respondent was adamant that while SG was administered two bags of normal saline solution, he was given 500-milliliter bags of solution. Therefore, SG received only a total of one liter of fluids. But an internal billing document indicates SG was charged for two 1000-milliliter bags of fluid at the rate of "400.00/500cc x 4." Furthermore, SG's mother was certain at hearing that the two bags of saline solution she saw administered to her son were "double the size" of the 500-milliliter bag of saline solution admitted into evidence as Exhibit B.

47. Respondent eventually discharged SG. On SG and his mother's way out of the clinic, a medical assistant stopped them and told the mother she owed a balance of \$326 for her son's treatment. She explained she should not owe anything other than the co-payment she paid upon arrival. But the medical assistant stated her plan only pays 80 percent of the total charges, and she is responsible for the remaining 20 percent. SG's mother charged \$326 to her credit card at 5:29 p.m.

48. At all relevant times, 24/7 Urgent Care Clinic was an authorized provider under the Blue Cross Prudent Buyer plan. Advantek Benefit Administrators, the third-party plan administrator for the Blue Cross Prudent Buyer insurance plan during the relevant time, issued an Explanation of Benefits on November 12, 2010. The Explanation of Benefits indicates 24/7 Urgent Care Clinic submitted an insurance claim in the amount of \$1,700 for SG's September 5, 2010 visit. Under the contract pursuant to which 24/7 Urgent Care Clinic was an authorized provider, it was entitled to only \$139.31 from Blue Cross for those services, and SG owed no deductible or co-payment.

49. The November 12, 2010 Explanation of Benefits indicates 24/7 Urgent Care Clinic was issued a check as payment of its claim for services provided SG on September 5, 2010. SG's mother returned to 24/7 Urgent Care Clinic to talk to respondent about the status of the refund for overpayment. The receptionist initially told her respondent refused to come and speak with her, but then SG's mother saw respondent walking in the back office. SG's mother called out to respondent and asked why he was refusing to refund her overpayment. A verbal altercation ensued between the two of them, during which respondent called SG's mother a "stupid jungle animal" and stated his office was not a "jungle" but a professional place of business.

50. Respondent continued to insult SG's mother, and eventually instructed the receptionist to contact the police. The police arrived and escorted SG's mother out of the

office, explaining her issue with respondent was a civil matter. Respondent refunded SG's mother's overpayment on July 29, 2011.

#### PATIENT AJ

51. AJ presented to 24/7 Urgent Care Clinic on August 2, 2012, for treatment of a persistent nosebleed. She was dissatisfied with the treatment received, and filed a consumer complaint with the Board on October 5, 2012. The complaint was assigned to Ms. Sanchez-Bartunek for investigation, and she requested AJ's medical records from 24/7 Urgent Care Clinic as part of that investigation. Cecilia Borbon responded in writing to that request on behalf of 24/7 Urgent Care Clinic as follows:

I have definitely searched every place in our office and was not able to retrieve the chart. At the time the patient was seen there was only one employee in the office. I have spoken to her about the chart and she has no idea what might have happened to it. I greatly apologize.

At this time, I definitely know that the patient was seen with us because I have attached with this letter proof of the patients [sic] payment for the visit and also proof of documentation in our logbook that she was seen & that there was [sic] phone calls back and forth from the front desk to the patient.

Thank you for being so patient with us while trying to retrieve the chart.

#### PATIENT DM

52. DM was a 64-year-old male who presented to 24/7 Urgent Care Clinic on September 30, 2009, after fainting in a sauna, suffering a laceration to his head, and suffering dizziness. Respondent treated the patient with IV fluids, a tetanus shot, and antibiotics. He diagnosed the patient with moderate dehydration, a head laceration, dizziness, and syncope.

53. Respondent did not determine the cause of DM's syncope, did not conduct a neurological examination, and did not perform any cardiac monitoring. He also did not thoroughly examine DM's head wound. Respondent's documentation of his examination of DM did not include a review of the multiple systems that should have been reviewed under the circumstances, a differential diagnosis, or discharge instructions.

54. Respondent admitted multiple times during Ms. Sanchez-Bartunek's interview that his medical records were incomplete, explaining "again, I keep going to the fact that this chart was not complete. It needed to be completed before it was sent to the medical board." DM's medical records were provided to the Board on November 25, 2013, and respondent

provided no explanation why he had not completed the records sometime during the more than four years that had elapsed since the date he treated DM.

#### PATIENT LS

55. LS was a 55-year-old female who presented to 24/7 Urgent Care Clinic on June 30, 2013, with a laceration to the tip of her index finger that occurred while she was making a sandwich for her son. She was examined by a physician assistant, who cleaned the wound with betadine, applied dermabond (sterile superglue), and bandaged the wound. The physician assistant prescribed antibiotics for five days and pain medication.

56. The physician assistant prepared a medical chart documenting treatment of LS. She signed the chart, and wrote Dr. Charles Phillips's name in block letters to indicate he was her supervising physician. Dr. Phillips did not countersign the chart. At the time, there were written protocols governing Dr. Phillips's supervision of the physician assistant that were signed by both of them.

57. The receptionist informed LS upon her arrival at 24/7 Urgent Care Clinic on June 30, 2013, she was required to pay a \$50 co-payment. LS gave the receptionist her credit card, but then realized her insurance card indicated the co-payment was only \$15. When LS questioned the receptionist, she was told it was "too late." LS signed the credit card receipt for \$50.

58. Two days later, LS called 24/7 Urgent Care Clinic and requested a refund of her \$35 overpayment. She was told the fastest way to get a refund was to provide her credit card information, but she did not feel comfortable doing so and said she would wait for a refund check.

59. At the time, LS had health insurance through Anthem Blue Cross. Once she received a copy of the Explanation of Benefits covering her June 30, 2013 treatment, she called 24/7 Urgent Care Clinic to check on the status of her refund. She was given the "runaround" for the next couple of months.

60. The Explanation of Benefits identified respondent as an authorized provider under LS's insurance plan. It indicated LS's insurance paid respondent 100 percent of the "Allowed Amount" for the services provided LS on June 30, 2013, and LS was required to pay only \$15 for those services. Respondent did not refund LS's overpayment until December 2014.

#### PATIENT MH

61. MH was a 38-year-old woman who presented to 24/7 Urgent Care Clinic on September 5, 2014, with complaints of cough and congestion for six days. A medical assistant took MH's vital signs, recorded her chief complaint and current medications, and put her in an examination room. The medical assistant returned and administered MH a

nebulizer breathing treatment. At no time during the visit was MH examined by a physician, physician assistant, or nurse practitioner.

62. Respondent admitted at hearing that neither he nor any other licensed health care provider was in the office at any time during MH's visit on September 5, 2014. Instead, the medical assistant contacted respondent by telephone after taking MH's vital signs and chief complaint. Respondent gave the medical assistant a "verbal order" to start MH on a nebulizer breathing treatment while he was in route to the clinic. His order was never documented in writing in the patient's medical chart.

#### PATIENT HR

63. HR was an 89-year-old male who presented to 24/7 Urgent Care Clinic on May 20, 2014, at approximately 7:30 p.m. after falling and suffering a skin tear to his left elbow and extensive bruising and swelling to his left arm and left cheek. He was accompanied by his daughter and his girlfriend. The three of them were shown to an examination room by a medical assistant, who prepared the room for suturing. Respondent briefly entered the room, looked at HR, commented "this will take some time," and left.

64. Respondent returned to the examination room, sat down, and prepared himself for suturing HR's skin tear. As he started to suture the wound, HR's girlfriend advised respondent HR was on Coumadin, and asked respondent not to suture the wound. Respondent stood up and asked, "who are you to tell me with my level of training what I should do?" The daughter then asked respondent to clean the wound, and explained she would bring her father to his primary care physician for further treatment. Respondent again asked, "who are you to tell me what to do?" He continued to yell at HR's daughter and girlfriend, stood up and walked out of the examination room, and instructed a staff member to call an ambulance.

65. As the ambulance crew was preparing HR for transport to the hospital, his daughter asked the receptionist for a bill. Respondent overheard the request, instructed the clerk "you do not give her anything," and told the daughter to call the billing department. The emergency medical technician with the ambulance company requested any available medical records, but respondent again refused to provide any documentation, yelling at the daughter that she needed to call the billing clerk for records.

66. Members of respondent's staff documented the interactions between respondent and HR's daughter and girlfriend in writing. Those reports indicate the interactions occurred between 8:50 and 9:20 p.m.

#### PATIENT SMG

67. SMG was a 36-year-old female who presented to 24/7 Urgent Care Clinic on May 20, 2014, with complaints of vaginal itching and malodorous discharge after unprotected sex one month prior. Respondent evaluated the patient, and documented her

appearance, head and neck exam, lung exam, and abdominal exam. He did not perform a pelvic examination, but took a vaginal swab and ordered the culture to be sent for laboratory analysis. He documented on the medical charts that the culture was sent to the laboratory.

68. Respondent diagnosed SMG with bacterial vaginosis and initially ordered "Rocephin 1 mg." However, he crossed that order out, and instead prescribed doxycycline, 100 milligrams twice daily for seven days. He told SMG to return in one week for her laboratory results.

69. On May 30, 2014, SMG called 24/7 Urgent Care Clinic for her laboratory results, and was told they were lost. Nonetheless, she went to the clinic later that day to get the results. She was placed in an examination room while she waited for her results. No medical record of her visit was prepared.

70. After waiting for about an hour, SMG stepped out of the examination room and asked how much longer she would have to wait. Respondent saw her and asked, "what are you doing out of the room?" She explained the room was too hot for her, and she was told her laboratory results were lost. Respondent raised his voice and told her she was being rude and uncooperative, and asked her to leave. He told her in front of other patients, "you should be ashamed of yourself." Respondent told the receptionist to call the police, and a medical assistant escorted SMG out of the office.

71. Respondent's interactions with SMG were witnessed by Anna Bello, a medical assistant working at 24/7 Urgent Care Clinic at the time. She explained at hearing, "And Dr. Ekelem kept yelling, 'This is not 7-11, I need you to go back to your room.' And the confrontation was just back-and-forth with a very loud voice."

#### PATIENT MT

72. MT was a 36-year-old male who presented to 24/7 Urgent Care Clinic on June 17, 2012, with a bee sting to his hand. Respondent evaluated the patient, and documented on the medical chart "Right hand bee sting 9 pm last night," "hand is swollen." He drew a picture of a hand with a dot in the middle indicating where MT was stung.

73. Respondent documented his diagnosis on the medical chart as "Right Hand Abscess, Cellulitis, and Bee Sting." He treated MT by performing an incision and drainage, suturing the area of the bee sting, and administering one milligram of Rocephin intramuscularly, 50 milligrams of Benadryl intramuscularly, and 60 milligrams of Kenalog intramuscularly. Respondent did not document a procedural note on the medical chart describing the procedure, what materials were used for suturing, what came out when he drained the wound, or MT's tolerance of the procedure.

74. Respondent billed MT's insurance company for laceration surgery, but the only laceration MT suffered was that which respondent caused during the incision and

drainage. The insurance company was also billed for a simple repair of a wound to the scalp, even though MT suffered no such wound and received no such treatment.

#### PATIENT VR

75. VR was a 38-year-old female who injured her shoulder on January 19, 2014, and sought medical treatment at 24/7 Urgent Care Clinic the following day. She was examined by Dr. Phillips, who ordered x-rays of her shoulder, prescribed Vicodin for pain, and prescribed antibiotics for a cough she complained of. He told her to return to have her x-rays reviewed.

76. VR had x-rays taken of her shoulder on January 21, 2014, and was given copies of the images on a compact disc to bring to 24/7 Urgent Care Clinic to have read, which she did the following day. There was no admissible evidence of which licensed medical provider, if any, she saw at 24/7 Urgent Care Clinic on January 22, 2014, but her medical chart indicates she was seen by someone to have her "MRI Results" read. She also was complaining of a cough, sore throat, and headache. The chart further indicates she was weighed, her temperature and pulse rate were taken, and her oxygen saturation level was read using a pulse oximeter. The chart contains the preprinted entry "PulseOX:" with a space after the entry to note the patient's oxygen saturation level, which was documented as "100%." for VR.

77. VR's medical chart contains no entries indicating she underwent a physical examination, was counseled regarding any medical issues, or was provided any medical care on January 22, 2014. Nonetheless, her health insurance was billed for a detailed office visit.

#### PATIENT BH

78. BH was a 57-year-old female who presented to 24/7 Urgent Care Clinic on August 7, 2013, complaining of a twisted right ankle. She was treated by Nurse Practitioner Christiana Okonkwo. Ms. Okonkwo performed a full physical examination of BH, and documented her findings on the medical chart. She drew a picture of the lower portion of the leg, starting with the shin, and the foot, noted the injury by scribbling marks at the ankle, and labeled the picture "Rt Ankle." Ms. Okonkwo diagnosed BH with a "RT Ankle Sprain," prescribed pain medication and a surgical boot, ordered an x-ray of the right ankle, and instructed BH to keep her right leg elevated and to apply ice to her ankle as needed for pain.

79. Ms. Okonkwo saw BH two days later to review her x-rays. The medical assistant who brought BH into the examination room took her weight, but did not take any vital signs. She documented BH's chief complaint on the medical charts as "Came to read MRI results. Ankle still swollen/pain."

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80. Ms. Okonkwo performed a full physical examination of BH, and documented her findings on the medical chart by noting that BH was "A/O x 3," "HEENT - WNL," "Lung - clear bilat[erally]," and "Chest - S1S2 WNL R R R."<sup>5</sup> She did not document having examined BH's right ankle, but explained at hearing "you know, definitely, because if I didn't do that, there is no way I can come with [sic] up with a plan." And she documented her treatment plan on the medical chart as "Reviewed MRI results," "Pt to contd on pain med," "• Ext applying ice," and "Surgical boot to Rt foot."

81. An internal coding sheet prepared by the billing staff at 24/7 Urgent Care Clinic identifying the services for which BH's health insurance should be billed indicates she should be charged for both a detailed office visit and a follow-up visit on August 9, 2013. There was no admissible evidence of the service or services for which the insurance company was actually billed.

### *Causes for Discipline Which Fail as a Matter of Law*

#### PATIENT DN

82. The Thirteenth, Fourteenth, Fifteenth, Sixteenth, and Seventeenth Causes for Discipline allege respondent committed gross negligence, engaged in dishonesty, aided/abetted the unlicensed practice of medicine, committed repeated negligent acts, and failed to maintain patient records with regard to the treatment and care provided DN at 24/7 Urgent Care Clinic on September 13, 2010. In particular, it is alleged that: 1) "respondent's failure to take a complete history and physical of D.N. constitutes an extreme departure from the standard of care" and his "administration of insulin instead of tetanus to D.N. constitutes an extreme departure from the standard of care;" 2) "he was not honest with the Medical Board investigators regarding his care and treatment of patient D.N." and "neither Respondent nor any other physician saw D.N.;" 3) "respondent was not present when his medical assistant saw D.N. and administered the 'tetanus' shot, and Respondent did not approve the administration of the 'tetanus' shot;" 4) "respondent's failure to take a complete history and physical of patient D.N. is a departure from the standard of care," his "failure to sign the chart when administering a shot to D.N. is a departure from the standard of care," his "failure to address D.N.'s low blood pressure is a departure from the standard of care," his "billing of D.N. for medical services that were not performed is a departure from the standard of care," and his "administration of insulin instead of tetanus to D.N. is a departure from the standard of care;" and 5) respondent "failed to maintain adequate and accurate records in his care and treatment of patient D.N."

83. Factual statements alleged in support of causes for discipline constitute judicial admissions. (*Myers v. Trendwest Resorts, Inc.* (2009) 178 Cal.App.4th 735, 747.)

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<sup>5</sup> Alert and oriented times three; head, eyes, ears, nose, and throat within normal limits; lungs clear bilaterally; and chest sounds within normal limits and regular rate and rhythm.

Facts which constitute judicial admissions are conclusively established, and it constitutes reversible error to find in contravention to those facts. (*Valerio v. Youngquist Construction* (2002) 103 Cal.App.4th 1264.) Here, complainant alleged inherently contradictory factual statements in support of five causes for discipline against respondent – respondent treated D.N. (gross negligence, repeated negligent acts, and failure to maintain patient records), and respondent did not treat D.N. (dishonesty and aiding/abetting). “While inconsistent theories of recovery are permitted (citation), a pleader cannot blow hot and cold as to facts positively stated.” (*Manti v. Gunari* (1970) 5 Cal. App.3d 442, 449; *Berman v. Bromberg* (1997) 56 Cal.App.4th 936, 944-945 [“A party may plead inconsistent causes of action so long as ‘there are no contradictory or antagonistic facts [citation]’”], quoting *Steiner v. Rowley* (1950) 35 Cal.2d 713, 718-719.) Therefore, the Thirteenth, Fourteenth, Fifteenth, Sixteenth, and Seventeenth Causes for Discipline fail as a matter of law.

#### PATIENT WL

84. The Eighteenth Cause for Discipline alleges respondent engaged in repeated negligent acts with regard to the treatment and care WL received on September 13, 2012, at 24/7 Urgent Care Clinic. Specifically, complainant alleged:

Respondent is subject to disciplinary action under Code section 2234(c) [sic] in that he failed to properly evaluate the patient’s condition prior to attempting to authorize his medical assistant to administer treatment. Respondent’s medical assistant is not sufficiently trained and licensed to determine proper therapy. Respondent’s failure to properly evaluate the patient’s condition prior to authorizing his medical assistant to administer treatment is a departure from the standard of care.

85. “Unprofessional conduct” includes “repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.” (Bus. & Code, § 2234, subd. (c).) Complainant alleged only one negligent act or omission in the Eighteenth Cause for Discipline, and that cause for discipline fails as a matter of law. (*Zabetian v. Medical Board of California* (2000) 80 Cal.App.4th 462, 468 [“The history of these amendments and the comments thereto supports a construction of the phrase ‘[r]epeated negligent acts’ to mean two or more acts”].)

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### *Expert Witnesses*

86. Complainant disclosed Roneet Lev, M.D., F.A.C.E.P., and Mandaar Gokhale, M.D., as expert witnesses pursuant to Business and Professions Code section 2334. Drs. Lev and Gokhale testified at hearing, and their written reports were admitted into evidence.<sup>6</sup>

87. Respondent disclosed Diva S. Seddick, M.D., C.M., F.A.A.P., as an expert witness pursuant to Business and Professions Code section 2334. He did not disclose himself as an expert witness. Dr. Seddick did not testify at hearing, and none of her written reports was admitted into evidence. To the extent respondent offered expert opinions during his interviews by Ms. Sanchez-Bartunek or at hearing, they were not considered. (See *In the Matter of the Accusation Against Jill Siren Meoni, M.D.* (2011) Precedential Decision No. MBC-2011-01 DMQ.)

#### DR. LEV

88. Dr. Lev obtained her undergraduate degree in chemistry, with honors, from California State University, San Bernardino, in 1983. Six years later, she obtained her medical degree from University of Texas Health Science Center in San Antonio, Texas. She then completed a one-year internship in Transitional Medicine at San Bernardino County Medical Center, followed by a three-year residency in Emergency Medicine at University of California San Diego Medical Center, during the final year of which she served as Chief Resident. She has been a fellow of the American Board of Emergency Medicine since 1995.

89. Dr. Lev is licensed to practice medicine in California under Physician's and Surgeon's Certificate Number G 48648, which expires October 31, 2019, unless renewed or revoked. There is no history of prior discipline of her certificate. She has been board-certified in Emergency Medicine by the American Board of Emergency Medicine since 1995.

90. As of the date of hearing, Dr. Lev has worked as a physician for Pacific Emergency Providers at Scripps Mercy Hospital in San Diego, California, since 2005. Prior to that, she worked as a physician for Emergency Physician Medical Group, also at Scripps Mercy Hospital, for 11 years. She has also worked as a physician for Balboa Naval Medical Center, Life Flight San Diego, Kaiser Foundation Hospital, and Associated Emergency Physicians Medical Group. While with Associated Emergency Physicians Medical Group, she worked at Paradise Valley Hospital, Valley Medical Center, the San Diego Jail, and the Vista Jail.

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<sup>6</sup> The opinions expressed by Drs. Lev and Gokhale for which no factual basis was proven were not considered and are not discussed below. (*Kennemur v. The State of California* (1982) 133 Cal.App.3d 907, 923-924 [an expert opinion is only as valuable as the facts upon which it is based].) The opinions pertaining to those causes for discipline which fail as a matter of law were not considered and are not discussed below either.

PATIENT SC

**AMOUNT OF FLUIDS ADMINISTERED**

91. Dr. Lev described a fluid bolus as a method of administering a set amount of fluids, as opposed to a continuous flow of fluids over a set period of time. She further explained the standard of care for administering fluids to a dehydrated patient with normal kidney function and who is not in congestive heart failure is to administer either a 500-milliliter bolus or a one-liter bolus of fluids. Additional boluses may be given if medically indicated after reassessment of the patient.

92. Dr. Lev described SC as "a stable patient." Nonetheless, respondent administered four one-liter boluses of fluids over a three-hour period of time on January 1, 2010. Dr. Lev explained the danger of administering that amount of fluids over that period of time was the risk of causing SC to suffer "fluid overload which affects the heart and lungs." She further explained a patient who was so dehydrated as to require four liters of fluids "is expected to have some signs of shock because that is a significant amount. And four liters may be necessary, but that would require transfer to an emergency department and not treatment in an urgent care." Respondent did not document on the medical chart anything to indicate SC was in shock.

93. Dr. Lev also explained:

The chart does not show justification for this quantity of hydration. The diagnosis was "severe/moderate" dehydration. The patient was noted to be cold and clammy, mildly febrile, and mild sunken eyes". This would justify one liter of fluid and reassessment. In an emergency department setting, a patient who requires 4 liters of fluid would have signs of shock such as tachycardia or hypotension which this patient did not have.

[SC] stated she felt chest tightness and palpitation that evening and her symptoms could have resulted from fluid overload. The amount of fluid administered to the patient could have endangered her health.

94. Dr. Lev opined that respondent's conduct constituted an extreme departure from the standard of care, explaining:

My opinion was an extreme departure because if the patient was so sick that they really needed four liters of fluids, then they should not have been in an urgent care, they should have been in an emergency department. And if they were not so sick, then that's an excessive amount of fluids and there was no justification or reassessment between liters of fluids.

### **FAILURE TO OBTAIN A COMPLETE HISTORY, OBTAIN A STOOL CULTURE OR PERFORM A RECTAL EXAMINATION, AND COMPLETE AN IV LOG**

95. The applicable standard of care for treating a patient with a prior history of diverticulitis who is complaining of bloody stools is to assess the cause and severity of the bloody stools. A rectal exam is necessary in order to visualize and decide how much blood is coming out, and to determine whether the patient in fact has bloody stools or instead has an anal fissure or some other trauma to her anal canal that is causing blood to mix with her stools. If the rectal exam is positive for blood or there is a real concern for dysentery, a stool culture is necessary to determine exactly what is wrong with the patient.

96. Dr. Lev observed that respondent did not perform a rectal examination or obtain a stool culture. Nor did he document in the medical chart how many stools a day SC had or elaborate on her abdominal pain or fever.

97. The applicable standard of care requires physicians who use IV logs to complete the log for each patient to whom IV fluids are given. Respondent claimed an IV log is completed for every patient who receives IV fluids. However, he could not produce one for SC.

98. Dr. Lev opined that respondent's failures to obtain a complete history from SC and obtain a stool culture or perform a rectal exam each constituted a simple departure from the standard of care. She further opined that his failure to complete an IV log constituted a simple departure.

### **FAILURE TO SIGN MEDICAL CHART**

99. The applicable standard of care requires the person who makes entries on a medical chart to sign or initial the chart. This is important in case questions arise in the future about the treatment and care provided the patient. It is particularly important when medication is administered. Dr. Lev opined that respondent's failure to sign or initial the entries he documented on the medical chart was a simple departure from the standard of care. She explained it was a simple departure, rather than an extreme departure, because of the relatively small size of 24/7 Urgent Care Clinic, and the relative ease with which one could presumably determine the treatment provider by determining who worked that day.

### **FAILURE TO REPEAT VITAL SIGNS AFTER ADMINISTERING FLUIDS**

100. The standard of care for administering multiple fluid boluses requires the physician to reassess the patient, including taking her vital signs, after each bolus and prior to starting another one. This reassessment is necessary in order to assess how the patient is responding to the fluids and to determine whether an additional bolus is necessary.

101. The only vital signs documented on SC's medical chart are those that were taken shortly after she arrived at 24/7 Urgent Care Clinic. Dr. Lev opined that the failure to reassess SC's vital signs after each fluid bolus was a simple departure from the standard of care.

#### **FAILURE TO CONSIDER A BROADER DIFFERENTIAL DIAGNOSIS**

102. The applicable standard of care is for a physician to use his best clinical judgment in reaching a diagnosis based on the patient's objective and subjective symptoms. Dr. Lev explained:

The diagnosis of acute gastroenteritis implies viral, bacterial, or irritant cause for vomiting and diarrhea. Dysentery implies diarrhea with blood or mucus, which can occur from a virus, bacteria, or parasite.

[¶ . . . ¶]

The patient complained of nausea, vomiting, diarrhea, rectal bleeding, and abdominal pain. There are several possibilities to the diagnosis besides gastroenteritis. [SC] was more likely to have a recurrence of the prior diverticulitis flare than gastroenteritis. She could have had significant gastrointestinal bleeding. An adequate assessment was not done to make a definitive diagnosis of gastroenteritis.

103. Dr. Lev opined that respondent committed a simple departure from the standard of care by diagnosing SC with gastroenteritis/dysentery based on the subjective complaints and objective findings documented on the medical chart. She explained:

That the diagnosis cannot be concluded based on the exam -- by the -- based on the lack of exam and lack of history. It's unclear how many times a day the patient had diarrhea. If it's a lot of watery stools or loose stools or -- it's unclear this person had bleeding from diverticulitis given blood in the stool and abdominal pain, so there's too many possibilities as to what the diagnosis could be in this patient to conclude that the patient had dysentery or diverticulitis [sic].

#### **ADMINISTERING ROCEPHIN FOR GASTROENTERITIS**

104. The applicable standard of care is for the physician to use his best clinical judgment in determining the appropriate medication for treating the patient's ailment. Dr. Lev opined that respondent committed a simple departure from the standard of care by prescribing Rocephin to treat SC. She explained Rocephin is not the correct antibiotic to

treat diverticulitis, and the infections that cause gastroenteritis “are usually viral or self limiting [sic].” “So antibiotics need to be catered to the right diagnosis and here there is a mismatch.”

#### **ALTERING MEDICAL RECORDS AFTER THE PATIENT LEAVES**

105. The applicable standard of care is for a physician not to alter medical records. Dr. Lev explained:

There are two versions of the same medical records for [SC]. The patient provided one set of records to the medical board, (tab 2 in binder). This record has an incomplete history and physical and documents only 3 liters of fluids.

The other version of the medical record was provided by Ekelem (tab 4 in binder), includes a more detailed exam, the fourth IV fluid and more detailed discharge instructions. This record certainly was completed after the patient left. It is written with a different pen. It is not clear how long after the visit the documentation was revised.

106. Dr. Lev opined that respondent’s altering SC’s medical records constituted a simple departure from the standard of care. She explained it was possible the records were altered shortly after SC left 24/7 Urgent Care Clinic on January 1, 2010, in which case the departure was only a simple one. However, if the alterations were made in anticipation of the Board’s investigation of respondent, it would be an extreme departure. Dr. Lev gave respondent the benefit of the doubt.

#### **PATIENT LV**

#### **FAILURE TO DOCUMENT MEDICAL HISTORY ON MEDICAL CHART**

107. The applicable standard of care requires a physician treating a patient in an urgent care setting to inquire about the patient’s past medical history and to document the patient’s response. Such information helps guide the physician’s diagnosis and formulation of treatment options. Here, respondent did not document any past medical history. But since he documented abnormal lung sounds, it would have been important to know if the patient had a history of asthma or a pulmonary disorder. Dr. Lev opined that respondent’s failure was an extreme departure because not documenting any history “falls greatly below [the] standard of care in the community.”

#### **ADMINISTERING ROCEPHIN WITHOUT OBTAINING A CHEST X-RAY**

108. The applicable standard of care is that a chest x-ray is necessary to diagnose pneumonia. Dr. Lev explained, “the patient is documented to have rhonchi on exam and

treated with Rocephin for pneumonitis and sinusitis. It is unclear what the diagnosis of pneumonitis implies. Pneumonitis typically implies irritation or inflammation of the lung, which does not require antibiotics. A diagnosis of pneumonia implies an infection to the lung that is evident on a [chest x-ray]. If antibiotics were given for an infection in the lung, then a [chest x-ray] would be indicated.” She opined that respondent’s administration of Rocephin without obtaining a chest x-ray was an extreme departure from the standard of care.

#### ADMINISTERING KENALOG FOR PNEUMONITIS OR SINUSITIS

109. The applicable standard of care is for a physician to not administer medication that is contraindicated for his diagnosis. Dr. Lev explained:

Kenalog is a long acting steroid injection typically used for treating inflammatory processes. Steroids are not indicated for infections such as sinusitis or pneumonia. Steroids are beneficial for asthma, emphysema, or reactive airway problems. For pulmonary conditions requiring steroids, oral prednisone or IV solumedrol is typically used. In an acute pulmonary condition there is no indication for administering steroids without also administering an inhaler unless the patient has an allergy or reaction to inhalers.

[¶ . . . ¶]

Kenalog was prescribed for sinusitis and pneumonitis. There was no diagnosis of asthma, emphysema or reactive airway to indicate the use of a steroid. Although the patient was given a prescription of pro-air inhaler, she did not get treated with inhalers during her urgent care visit to indicate that the diagnosis of pneumonitis had a reactive airway component.

[¶ . . . ¶]

If indeed the patient had pulmonary irritation defined as reactive airway disease, then kenalog is not the drug of choice. In this situation oral prednisone or IV solumedrol would be used. Oral and IV steroid [sic] are considered equivalent in many cases and only severe reactive airway would require IV steroids. IM kenalog was not indicated for this patient for the diagnosis given or for a potential diagnosis of reactive airway.

Dr. Lev opined that respondent’s departure was an extreme departure “because [Kenalog] is not indicated for pneumonitis or sinusitis and is not the drug of choice for a patient with pulmonary inflammation.”

### **FAILURE TO DOCUMENT HISTORY, PAST MEDICAL HISTORY, AND RESPIRATORY RATE ON MEDICAL CHART**

110. The applicable standard of care is for a physician to inquire about and document the history of the patient's current complaints and her past medical history. The standard of care also requires the physician to obtain a complete set of the patient's vital signs. Here, respondent did not document any history, and he documented each of LV's vital signs, except for respiratory rate. History is important because it assists the physician with formulating a diagnosis and a treatment plan. LV's respiratory rate was particularly important given the nature of her subjective complaints.

111. Dr. Lev opined that respondent's failure to document LV's past medical history was an extreme departure from the standard of care. However, she opined that the failure to document the history of LV's current complaints and respiratory rate were only simple departures from the standard of care.

### **FAILURE TO PROPERLY ADMINISTER KENALOG INJECTION**

112. The applicable standard of care requires that Kenalog injections be made into the deep muscle, and not into the subcutaneous fat. Here, Kenalog was injected into LV's subcutaneous fat, which resulted in lipodystrophy, a loss of fat caused which results in a dent at the injection site. Dr. Lev opined that the administration of a Kenalog injection into the subcutaneous fat is a simple departure.

### **PATIENT SG**

#### **ADMINISTERING EXCESSIVE FLUIDS**

113. Dr. Lev explained the following regarding the applicable standard of care:

The standard of care for IV fluid management in pediatrics is well established [*sic*]. According to PALS (Pediatric Advanced Life Support) children who are dehydration [*sic*] should receive a bolus of IV Normal Saline or Lactated Ringers at a dose of 20cc/kg and re-examined. If they still appear dehydrated, then additional fluid boluses can be administered. This formula is well known [*sic*] to anyone who treats emergency or urgent children.

[SG] was documented to weigh 32 pounds, which is 14.5 kg. This means that the fluid bolus should have been 290 cc. A child who requires multiple fluid boluses is most likely extremely ill, in shock, and would require emergency treatment and hospital admission. Such a child would require labs to

evaluate electrolytes and a workup for causes and consequences of such severe dehydration.

Maintenance fluids can be calculated by the formula that Dr. Ekelem implied in his interview with the medical board. Specifically [sic] he states that 100cc/kg is given for the 10 kg and 50 cc/kg is given for the next 10 kg. However [sic] this maintenance dose is for a 24-hour period. Using this formula, a child weighing 14.5kg would require less than 1250cc in a 24 hours [sic] period or 52cc per hour.

There are pediatric fluid calculators available online or as applications on cell phones. Using the weight of 32 pounds and moderate dehydration listed in Ekelem's diagnosis the fluid administration during the first 8 hours of treatment would be 887cc or 111cc/hr or 444 in 4 hours.

114. SG was given two liters of fluids over a three-hour period. Therefore,

Using the 100/50 formula for maintenance fluid, this patient should have received 156 cc of maintenance fluids in a 3-hour period. The 2 liters given are 12.8 times that amount.

Using the pediatric fluid calculators with an assumption of severe dehydration, the child should have received 333 cc in 3 hours and with this calculation the amount of fluids given was 6x the recommendations.

The PALS formula of 20cc/kg bolus would equal 290cc of fluid and therefore the 2 liters administered is 140cc/kg or nearly 7 times the recommended fluid.

Dr. Lev opined that giving SG two liters of fluids over a three-hour period was an extreme departure from the standard of care, because it was seven times the recommended amount based on the PALS formula, six times that recommended under the pediatric fluid calculators, and 12.8 times that recommended under the 100/50 formula.

#### **FAILURE TO PERFORM COMPLETE MEDICAL WORKUP OR ALTERNATIVELY REFER SG TO A HOSPITAL**

115. The applicable standard of care requires that a patient suffering from breathing difficulties undergo a full medical workup to determine the cause of the difficulties. Additionally, a child who is not moving or responding well requires laboratory evaluation and a full medical workup. Here,

Ekelem charts under "S", subjective: "seems to be breathing hard". Although the lungs are documented to be clear, there is no respiratory rate document and no CXR.

The chart states: "not moving or responding as well". This suggests a child who is gravely ill.

The medical evaluation also suggests a child who is ill with "sunken eyes, poor turgor, and tachypnea". The level of alertness is not documented.

The description in the history and physical are that of a very ill child who would warrant laboratory evaluation, [chest x-ray], urinalysis, and even transfer to a hospital. Only a UA was obtained.

116. Dr. Lev opined that respondent's failure to perform a complete medical workup of SG was an extreme departure "because a description of such an ill child would warrant referral to a hospital. Should the physician choose to treat the child solely in the urgent care, the equivalent workup and treatment should be provided."

#### **FAILURE TO DOCUMENT PAST MEDICAL HISTORY AND RESPIRATORY RATE ON MEDICAL CHART**

117. The applicable standard of care requires the physician to inquire about any past medical history and to obtain a complete set of vital signs for the patient. SG's documented vital signs did not include a respiratory rate, which would have been particularly important since respondent documented that SG appeared "to be breathing heavy." And for the same reason, it would have been important to document whether SG had a history of asthma, prematurity, or recent hospitalizations.

118. Dr. Lev opined that respondent's failures were simple departures "because there is some documentation and although it falls below the community standard, it is not grossly negligent."

#### **FAILURE TO COMPLETE IV LOG**

119. The applicable standard of care is to follow the medical facility's established procedure for documenting the administration of IVs. Here, 24/7 Urgent Care Clinic had an internal document on which the start time and end time for the IV is documented, as well as the patient's vital signs at 15-minute intervals throughout the administration of the IV. Respondent explained to Ms. Sanchez-Bartunek that an IV log is completed for every patient who receives an IV. The IV log created for SG contains the start time; his temperature, pulse, and oxygen saturation for the time entries "2:09" and "2:44," but no blood pressure for

either entry; and no vital signs for the 3:00 entry. Dr. Lev opined that the failure to complete the IV log was a simple departure.

### **INCORRECT DIAGNOSIS OF GASTROENTERITIS**

120. The standard of care applicable to diagnosing gastroenteritis is that the patient must have symptoms of vomiting and diarrhea. Dr. Lev explained, "so 'gastro' means stomach or irritating and is implied by vomiting and 'enteritis' is intestines which is implied by having diarrhea, so acute vomiting and diarrhea, it's both." Respondent specifically documented that SG had "no diarrhea." Nevertheless, his diagnosis was gastroenteritis. Dr. Lev classified respondent's departure as "a simple departure because there are physicians who make that mistake."

### **PATIENT HR**

### **DELAY IN CALLING AMBULANCE**

121. The applicable standard of care is that "an elderly patient who falls and sustains a head injury while taking Coumadin meets criteria for transfer to a trauma center for evaluation." Here,

[HR] sustained a fall while on Coumadin and a picture of his face shows very extensive bruising and swelling. [HR] was kept in the urgent care waiting room for over 1 hour. When Dr. Ekelem first saw the patient his reaction was "this will take some time." In fact, this patient should have taken no time at all. At the first look of the patient, 911 should have been called for care at an appropriate emergency department or trauma center.

Dr. Lev characterized the delay in calling an ambulance as an extreme departure from the standard of care.

### **INTENTION TO SUTURE WOUND**

122. The applicable standard of care is that a skin tear on a patient with fragile skin requires wound debridement and appropriate dressing, not suturing. Here,

The picture provided of [HR's] elbow shows a skin tear that is very superficial with extensive ecchymosis [*sic*] (bruising) and thin fragile skin. This type of wound would not be conducive to suturing. Dr. Ekelem was all set to suture the patient's elbow. However, this wound was not conducive for suturing as this skin was very thin, fragile, and already torn. Attempting to suture it could potentially create more tears in the skin. The treatment

for the wound would be to clean it with saline and place a sterile dressing with wound dressing material such as xeroform. Coumadin is not a contraindication to suturing. However, this patient required a stat PT/INR blood level to see if he was susceptible to bleeding given his extensive injuries around his head. Attempting to suture this wound shows a lack of knowledge by Dr. Ekelem.

Dr. Lev characterized respondent's intention to suture HR's skin tear as a simple departure.

#### **FAILURE TO PROVIDE MEDICAL RECORDS TO AMBULANCE PERSONNEL**

123. The applicable standard of care requires that copies of the patient's medical records be sent to the hospital with the EMTs or paramedics who transfer the patient. Respondent's refusal of HR's daughter's and the EMT's requests for medical records was a simple departure.

#### **PATIENT SMG**

#### **FAILURE TO COMPLETE A PELVIC EXAMINATION**

124. The applicable standard of care requires that a patient with a chief complaint of vaginal discharge receive a pelvic examination. Respondent admitted he did not perform a pelvic examination of SMG because he was not comfortable performing one since he is not a gynecologist. Dr. Lev characterized his failure to perform a pelvic examination as an extreme departure.

#### **FAILURE TO PRESCRIBE ROCEPHIN FOR POTENTIAL GONORRHEA**

125. The applicable standard of care for a patient with vaginal discharge and a possible sexually transmitted disease is to treat prophylactically for both gonorrhea and chlamydia. Dr. Lev explained:

A patient with a vaginal discharge and possible sexually transmitted disease required coverage for possible gonorrhea and chlamydia. This is true even if cultures are obtained since often the two diseases occur together and there can be false negative results. In addition, treatment for both infections should start before culture results are back when there is a high suspicion for infection. [SMG] was given antibiotic coverage of doxycycline 100 mg twice a day for 7 days. This is the correct coverage for potential chlamydia cervicitis, however [sic] it

does not cover gonorrhea. The patient should have received Rocephin for gonorrhea coverage.

Dr. Lev characterized the treatment of chlamydia without coverage for gonorrhea as an extreme departure.

#### **FALSE DOCUMENTATION THAT VAGINAL CULTURES WERE SENT**

126. The applicable standard of care is to send a patient's cultures to the laboratory if it is documented on her medical chart that they were sent. Dr. Lev opined that respondent's failure to send SMG's cultures to the laboratory was a simple departure.

#### **INCORRECT DIAGNOSIS OF BACTERIAL VAGINOSIS**

127. The applicable standard of care is for a physician's diagnosis to "match the patient's clinical findings and complaint." Dr. Lev explained:

Bacterial Vaginosis is a polymicrobial clinical syndrome. The diagnosis is made by use of laboratory testing or clinical criteria. The clinical criteria requires 3 out of the 4 following findings:

1. Homogeneous, thin, white discharge that smoothly coats the vaginal walls
2. Presence of clue cells on microscopic examination
3. pH of vaginal fluids > 4.5
4. The fish odor of vaginal discharge before or after adding KOH solution

Understanding this criteria and diagnosis it is impossible to state that this patient had Bacterial Vaginosis since she did not get a pelvic exam and there was no analysis of a vaginal discharge.

Dr. Lev characterized respondent's departure as a simple one.

#### **PATIENT MT**

#### **TREATMENT OF BEE STING WITH INCISION AND DRAINAGE**

128. The applicable standard of care requires a bee sting to be treated as an allergic reaction, rather than an infection that requires antibiotics or incision. Dr. Lev explained:

A bee sting is a type of anaphylactic chemical allergic reaction. The treatment for this reaction is antihistamines and occasionally steroids. An incision and drainage (I&D) of the wound is absolutely contraindicated. This is not a wound or

abscess with pus that requires drainage, but a local swelling reaction. Cutting into this wound exposes the patient to an infection and a worse reaction. The diagnosis of abscess and cellulitis is incorrect and the treatment of I&D is absolutely contraindicated.

Dr. Lev characterized respondent's performance of an incision and drainage for a bee sting reaction as an extreme departure

#### **FAILURE TO DOCUMENT PROCEDURAL NOTE**

129. The applicable standard of care is to prepare an appropriate procedure note each time a procedure is performed on a patient. While respondent documented on MT's medical chart that he performed an incision and drainage and sutured the wound, he did not include a procedure note describing the procedure, the materials used for packing or suturing, any drainage from the wound, or MT's tolerance of the procedure. Dr. Lev found such a failure to be an extreme departure from the standard of care.

#### **SUTURING AN ABSCESS**

130. The applicable standard of care is to not suture an abscess that requires an incision and drainage. Dr. Lev explained, "suturing and abscess is an absolute contraindication. An abscess has pus, and suturing pus would just make an infection worse. An I&D is always left open and usually requires packing to allow healing from the inside out." She characterized respondent's suturing of MT's abscess as an extreme departure.

#### **DR. GOKHALE**

131. Dr. Gokhale received his Bachelor of Arts in Political Science, with honors, from Yale University in New Haven, Connecticut, in 1989. Four years later, he received his medical degree from NYU School of Medicine in New York, New York. He then completed a one-year transitional internship at Shadyside Hospital in Pittsburgh, Pennsylvania, followed by a three-year residency in Emergency Medicine at George Washington/Georgetown University in Washington, D.C.

132. Dr. Gokhale is licensed to practice medicine in California pursuant to Physician's and Surgeon's Certificate Number G 84628, which expires October 31, 2019, unless renewed or revoked. There is no history of prior discipline of his certificate. He is also licensed to practice medicine in Virginia, Montana, Wyoming, Maryland, and Maine. He has been board-certified in Emergency Medicine by the American Board of Emergency Medicine since 1998.

133. As of the date of hearing, Dr. Gokhale has worked as an attending emergency physician at Downey Regional Medical Center in Downey, California, since 1999. He has also worked various assignments as an attending emergency physician for Comphealth

Locum Tenens since 2008. Prior to that, he worked various assignments as an attending emergency physician for Comphealth Locum Tenens from 1997 through 2000. He also has prior experience as an attending physician and clinical instructor in Emergency Medicine at The Medical College of Virginia in Richmond, Virginia.

PATIENT DM

**FAILURE TO PROPERLY EVALUATE PATIENT AND CONDUCT  
NECESSARY EXAMINATIONS AND MONITORING**

134. Dr. Gokhale said the following about the treatment and care required for patients such as DM:

The standard of care requires recognition of the various causes of syncope and directs treatment towards that cause. Although vasovagal or neurocardiogenic syncope is the most likely cause in most age groups, older patients or those who fall into positive risk stratification for cardiac disease require a cardiac evaluation. Neurological deficit or prolonged loss of consciousness mandates brain evaluation. Moreover, a traumatic physical finding such as head laceration only further calls for brain evaluation via CT scan. Syncope may actually be the manifestation or effect of a serious intracranial event (hemorrhage, less likely stroke), and not the cause.

135. Dr. Gokhale said the following about the treatment and care respondent provided DM:

[DM] presents with a head injury after a syncopal event and subsequent fall. He is noted to be dizzy, pale, cold and clammy, and slurring and stumbling, worrisome for cardiac or neurological condition. The only etiological diagnosis given is moderate dehydration. There is no neurological examination done, and no cardiac monitoring performed. He is treated for more than 2 hours without these evaluations. There is no physical examination of his head laceration, and treatment of this injury.

At the least, [DM], a 64 [sic] year-old gentleman, required a full physical exam with these elements, and documentation of recommended disposition which Dr. Ekelem says, in an interview, to be to an ED. However, the standard requires a screening EKG or monitor strip (not performed despite the usual ability in urgent care centers to perform them) and head CT which would require transfer to an ED emergently via private

auto with friend/family driver, or via ambulance. The most beneficial way to complete all required studies expeditiously would be to immediately call an ambulance, and if patient refuses transport, this can be duly documented. Antibiotics were administered not indicated.

136. Dr. Gokhale concluded:

Dr. Ekelem did not perform an adequate physical examination and treatment of this patient with sustained syncope who was manifesting signs and symptoms of other potentially catastrophic cardiac and neurologic conditions. The improvement in his blood pressure is noted, but no documentation of neurological improvement. This is a simple departure from the standard of care.

#### **FAILURE TO PROPERLY AND ADEQUATELY DOCUMENT TREATMENT**

137. Dr. Gokhale said the following about the applicable standard of care for documenting a patient's treatment:

The standard of care requires the maintenance of medical records for all patients. While guidelines vary state to state and based on type of practice, Medicare does require records to be maintained for 5 years in hospitals. Urgent care clinics are held to the same standard.

The records should be complete and included [sic] all aspects of care including triage, chief complaint, physical examination, treatment and rationale, outcome, disposition, and instructions. The chart should be signed. Any subsequent interaction with the patient regarding medical issues should also be recorded. In addition, prolonged care should have regular reassessment documented.

138. Dr. Gokhale said the following about respondent's documentation of DM's treatment:

Dr. Ekelem's chart has very scant documentation. This is more clearly evident in a case like this with multiple systems that need to be addressed. There is an absent neurologic and too brief of a cardiac examination. Differential diagnosis and rationale for treatment is not documented. Reassessment is not documented, nor issues related to disposition including instructions.

139. Dr. Gokhale concluded:

While Dr. Ekelem's transcribed and taped interview would suggest that more elements of the physical examination and treatment plan were performed and discussed, there is no documentation of them. Moreover, the chart is not signed by Dr. Ekelem. Dr. Ekelem's charting and patient visit record represent a simple departure from the standard of care.

### *Respondent's Credibility*

140. A detailed discussion of the substance of respondent's interviews by Ms. Sanchez-Bartunek or his testimony at hearing is not necessary because his demeanor while testifying and the manner in which he testified established he was not a credible witness. (See Evid. Code, § 780, subd. (a) [a witness's "demeanor while testifying and the manner in which he testifies" may be considered when evaluating credibility]; *People v. Jackson* (1989) 49 Cal.3d 1170, 1205-1206 ["[I]n determining the believability of a witness, the demeanor and manner of the witness while testifying [is] a factor to consider".]) He was instructed on multiple occasions throughout his testimony to limit his answer to the question asked, yet he repeatedly went beyond the scope of the question when it served his interests to do so. He also had to be instructed numerous times to answer the question asked after providing a self-serving, nonresponsive diatribe.

141. Respondent sometimes testified in great detail while on direct examination, but then claimed to have little memory of those same details when asked about them on cross-examination. (See *Shapiro v. Equitable Life Assurance Society of United States* (1946) 76 Cal.App.2d 75, 97 [a witness's inconsistent memory of certain facts while testifying on direct examination versus cross-examination impacts his credibility].) Other times he provided evasive answers or quibbled with the deputy attorney general about trivial matters. (See *Bohn v. Gruver* (1931) 111 Cal.App. 386, 393 [evasiveness and quibbling "often operate as effectively as an impeachment as does proof tending to contradict the witness"].)

142. Respondent also stated matters as fact even though he had no personal knowledge of those facts. For instance, he told Ms. Sanchez-Bartunek that an IV log is prepared for every patient. At hearing, however, he explained, "I've never written or put a line on any IV log sheet." He also testified, "I can -- like I said, I'm always there. I start the IV, hang up the fluid." The testimony was belied by SG's mother's testimony that it was the medical assistant who hung each bag of fluids for her son, not respondent. Also, she had to run out of the examination room to the receptionist for help when her son began suffering an allergic reaction to Phenergan. Her testimony was credible.

### *Character Witnesses*

143. Six character witnesses testified on respondent's behalf, five of whom are either current or former patients of respondent. The sixth is employed by respondent. Each

witness testified to the opinions that respondent is honest and compassionate. They each believe respondent enjoys a good reputation in the community. However, each witness, at best, had only a general understanding of the nature and extent of the allegations in the Third Amended Accusation.

### *Discussion*

#### PATIENT SC

144. The clear and convincing evidence established respondent engaged in an extreme departure from the standard of care by administering four liters of fluids to SC over a three-hour period without medical justification and reassessing her in between fluid boluses. He also engaged in departures from the standard of care in his treatment and care of SC by: 1) failing to obtain SC's complete history, obtain stool cultures or perform a rectal examination, and complete an IV log while administering fluids; 2) administering four liters of fluids over a three-hour period without medical justification and reassessing her in between fluid boluses; 3) not signing or initialing SC's medical chart after making entries; 4) not taking SC's vital signs after each bolus of fluids; 5) diagnosing SC with gastroenteritis without considering a broader differential diagnosis; 6) administering Rocephin when it was contraindicated; and 7) altering SC's medical chart after she left 24/7 Urgent Care Clinic. Respondent misrepresented to SC that he was an approved provider for Blue Shield and she was required to pay 20 percent of the total bill, and he failed to maintain adequate and accurate records regarding his treatment and care of SC on January 1, 2010.

145. There was insufficient evidence to establish respondent engaged in a dishonest or corrupt act by misrepresenting his professional credentials to SC or her daughter. There also was insufficient evidence respondent received a duplicate payment for services provided SC, or that he engaged in a departure from the standard of care by failing to sign her medical chart after administering medication to her.

#### PATIENT LV

146. The clear and convincing evidence established respondent engaged in an extreme departure from the standard of care by failing to document any history on LV's medical chart and by administering Rocephin to her for a pulmonary infection without obtaining a chest x-ray. He also engaged in departures from the standard of care by: 1) not documenting LV's history, past medical history, and respiratory rate on her medical chart; 2) administering Rocephin for a pulmonary infection without obtaining a chest x-ray; 3) administering Kenalog when it was contraindicated; and 4) his medical assistant's improper injection of Kenalog into LV's subcutaneous fat. Respondent failed to maintain adequate and accurate medical records of his July 8, 2010 treatment of LV.

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#### PATIENT SG

147. The clear and convincing evidence established respondent engaged in an extreme departure from the standard of care by giving SG an excessive amount of fluids and by not performing a full medical workup of SG or referring him to a hospital. He also engaged in a departure from the standard of care by: 1) not documenting SG's past medical history and respiratory rate on his medical chart; 2) giving SG an excessive amount of fluids; 3) not performing a full medical workup of SG or referring him to a hospital; 4) not completing an IV log for SG; and 5) incorrectly diagnosing SG with gastroenteritis. Furthermore, he committed a dishonest or corrupt act and engaged in general unprofessional conduct by misrepresenting the terms of SG's health insurance coverage. He also engaged in general unprofessional conduct by receiving duplicate payment for treating SG and delaying the refund owed SG's mother. Lastly, respondent failed to maintain adequate and accurate records of his September 5, 2010 treatment of SG.

148. There was insufficient evidence to establish respondent engaged in unprofessional conduct by referring to SG's mother in derogatory terms. While the clear and convincing evidence established respondent referred to SG's mother using derogatory terms, including referring to her as a "stupid jungle animal," there was insufficient evidence that such behavior sufficiently interfered with public health, safety, or welfare to supersede respondent's First Amendment rights.

149. There also was insufficient evidence to establish respondent engaged in a departure from the standard of care by not signing SG's chart after giving medication or documenting the placement of the IV. The undisputed evidence established it was respondent's medical assistant who administered the Phenergan and inserted the IV, not respondent.

#### PATIENT AJ

150. The clear and convincing evidence established respondent failed to maintain adequate and accurate records of his October 5, 2012 treatment of AJ. He did not dispute this contention.

#### PATIENT DM

151. The clear and convincing evidence established respondent engaged in a departure from the standard of care by: 1) improperly evaluating and treating DM, and 2) failing to document DM's treatment on his medical chart. He also failed to maintain adequate and accurate records of his September 20, 2009 treatment of DM.

#### PATIENT LS

152. The clear and convincing evidence established respondent failed to refund a duplicate payment received for LS's June 30, 2013 treatment.

153. There was insufficient evidence respondent engaged in an extreme departure from the standard of care by failing to ensure proper supervision of the physician assistant who treated LS. Complainant conceded as much in her closing brief.

PATIENT MH

154. The clear and convincing evidence established respondent did not document in writing his verbal order that his medical assistant start MH on a nebulizer breathing treatment.

PATIENT HR

155. The clear and convincing evidence established respondent engaged in an extreme departure from the standard of care by delaying calling an ambulance for HR. He also engaged in departures from the standard of care by: 1) trying to suture HR's skin tear; 2) not recognizing the potential for HR suffering a head injury and immediately referring him to an emergency room; and 3) refusing to provide medical records to ambulance personnel.

156. There was insufficient evidence respondent engaged in general unprofessional conduct by raising his voice with HR's daughter and girlfriend and berating them. While the clear and convincing evidence established he did in fact raise his voice with HR's daughter and girlfriend and berate them, there was insufficient evidence that such behavior rose to the level of constituting general unprofessional for the reasons explained in Factual Finding 148.

PATIENT SMG

157. The clear and convincing evidence established respondent engaged in extreme departures from the standard of care by failing to perform a pelvic examination on SMG and by not prescribing Rocephin prophylactically for gonorrhea. Furthermore, he failed to maintain adequate and accurate records of SMG's May 20, 2014 treatment.

158. There was insufficient evidence respondent engaged in a departure from the standard of care by failing to create a medical record of her May 30, 2014 visit. While the evidence established SMG went to 24/7 Urgent Care Clinic on May 30, 2014, to obtain her laboratory results and no record of that visit was created, there was no evidence she was placed in an examination room that day to discuss the results. In fact, it was uncontroverted that no results were discussed because the cultures were never sent for analysis.

159. There also was insufficient evidence to establish respondent engaged in a departure from the standard of care by falsely documenting that SMG's cultures were sent for laboratory analysis when they were not. Dr. Lev did not explain the effect, if any, of an internal mistake or error, on her analysis that respondent engaged in a departure from the standard of care with his false documentation. Therefore, her opinion was unpersuasive.

160. There was insufficient evidence respondent committed general unprofessional conduct by raising his voice and humiliating SMG in front of other patients. While the clear and convincing evidence established that respondent did in fact engage in the behavior alleged, there was insufficient evidence to establish such behavior rose to the level of constituting general unprofessional conduct for the reasons explained in Factual Finding 148.

#### PATIENT MT

161. The clear and convincing evidence established respondent engaged in an extreme departure from the standard of care when he treated MT's bee sting by performing an incision and drainage. He engaged in another extreme departure from the standard of care by failing to document the incision and drainage in a procedural note on MT's medical chart. He also engaged in a departure from the standard of care by suturing MT's abscess after performing the incision and drainage. Furthermore, respondent billed MT's health insurance for services not provided, and he failed to maintain adequate and accurate records of his treatment of MT on June 17, 2017.

#### PATIENT VR

162. The clear and convincing evidence established respondent billed VR's health insurance for performing a detailed office visit on January 22, 2014. However, he did not provide services consistent with a detailed office visit that day.

163. There was no admissible evidence respondent engaged in an extreme departure from the standard of care by failing to review VR's x-rays on January 22, 2014, because there was no admissible evidence he saw her that day. Nor was there any admissible evidence that he raised his voice at VR and humiliated her in front of other patients on that or any other day.

#### PATIENT BH

164. There was no admissible evidence of the services for which BH's health insurance was billed based on her August 7 or 9, 2014, visit with Ms. Okonkwo.

#### CLEARLY EXCESSIVE TREATMENT

165. The clear and convincing evidence established respondent provided clearly excessive treatment to SC by administering four liters of fluids to her during a three-hour window. While Dr. Lev explained that providing that amount of fluids within that period of time to an adult was not per se excessive, she persuasively explained it was excessive to give that amount of fluids to SC based on her physical condition when she presented to respondent for treatment on January 1, 2010. Additionally, respondent provided clearly excessive treatment to SG by giving him two liters of fluids during a three-hour window. Dr. Lev's explanation that the amount of fluids given SG on September 5, 2010, was six times that which is recommended by pediatric fluid calculators, seven times that which is

recommended by PALS, and 12.8 times that which is recommended by the formula used by respondent was persuasive.

#### DISHONEST OR CORRUPT ACTS OF 24/7 URGENT CARE CLINIC

166. There was insufficient evidence 24/7 Urgent Care Clinic engaged in the following business practices: 1) charged patients a \$50 urgent care fee and told them they would be reimbursed if their insurance paid respondent's insurance claim; 2) commonly diagnosed patients with dehydration, administered IV fluids, administered Rocephin, and billed patients in accordance with the amount which they stated they could afford to pay; and 3) completed IV logs after the fact and changed treatment notes to accommodate denials of health insurance claims. While Ms. Altman-Anderson described witnessing those practices while working for 24/7 Urgent Care Clinic and testified to the same at hearing, her statements and testimony were not credible. She worked for 24/7 Urgent Care Clinic for only one month, and she provided contradictory testimony. Additionally, her testimony was refuted by Ms. Borbon, who was a more credible witness.

#### RESPONDENT'S DISHONEST OR CORRUPT ACTS DURING MBOC INTERVIEW

167. Respondent was not honest when asked whether his Tennessee medical license has ever been disciplined. He stated it was not renewed because he did not appear for an interview with the Tennessee Board of Medical Examiners. But the clear and convincing evidence established his application to renew his license was denied because the Tennessee Board of Medical Examiners concluded he: 1) engaged in unprofessional, dishonorable, or unethical conduct, and 2) made false statements or representations, was guilty of fraud or deceit in obtaining his license, or was guilty of fraud or deceit while practicing medicine. The factual basis for the Tennessee Board of Medical Examiners's findings arose out of respondent's "conduct in relation to hospital privileges and the balance billing conduct regarding Blue Cross and Blue Shield."

168. There was insufficient evidence respondent was not honest during the MBOC investigation when he represented himself to be an "intensivist." Dr. Lev defined an "intensivist" as "a physician who specializes in intensive care, usually in an ICU (intensive care unit) setting." Respondent's education, training, and experience qualified him as an "intensivist" based on such definition.

169. There was no admissible evidence respondent was dishonest during the MBOC investigation when he said SG's mother voluntarily paid 20 percent of the total bill because she declined the option of waiting for her health insurance to be billed.

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## *Summary*

### GROSS NEGLIGENCE

170. Complainant established that cause exists to discipline respondent's physician's and surgeon's certificate based on his gross negligence with regard to the treatment and care provided SC, LV, SG, HR, SMG, and MT for the reasons explained in Factual Findings 144, 146, 147, 155, 157, and 161. Cause for discipline based on his alleged gross negligence with regard to the treatment and care provided DN, LS, and VR was not established for the reasons explained in Factual Findings 82 through 85 and 163.

### GENERAL UNPROFESSIONAL CONDUCT

171. Complainant established that cause exists to discipline respondent's physician's and surgeon's certificate based also on his general unprofessional conduct with regard to the treatment and care provided SC and SG (with regard to the misrepresentation of the terms of payment and the receipt of duplicate payment only) for the reasons explained in Factual Findings 144 and 147. Cause for discipline based on his alleged general unprofessional conduct with regard to the treatment and care provided SG (with regard to the use of derogatory language only), HR, SMG, and VR was not established for the reasons explained in Factual findings 148, 156, 160, and 163.

### DISHONEST OR CORRUPT ACTS

172. Complainant established that cause exists to discipline respondent's physician's and surgeon's certificate based also on his engaging in a dishonest or corrupt act with regard to the treatment and care provided SG, MT, and VR for the reasons explained in Factual Findings 147, 161, 162, and during the investigation by the Board (with regard to prior discipline of his Tennessee medical license only) as explained in Factual Finding 167. Cause for discipline based on his allegedly engaging in a dishonest or corrupt act with regard to the treatment and care provided SC, DN, or BH or during the Board's investigation (with regard to his representation that he is an "intensivist" and SC's voluntary payment only) was not established for the reasons explained in Factual Findings 82, 83, 145, and 164.

### FAILURE TO TIMELY REFUND DUPLICATE PAYMENT

173. Complainant established that cause exists to discipline respondent's physician's and surgeon's certificate also based on his failure to timely refund a duplicate payment to SG and LS for the reasons explained in Factual Findings 147 and 152. Cause for discipline based on his allegedly failing to timely refund a duplicate payment to SC was not established for the reasons explained in Factual Finding 145.

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#### REPEATED NEGLIGENT ACTS

174. Complainant established that cause exists to discipline respondent's physician's and surgeon's certificate also based on his engaging in repeated negligent acts with regard to the treatment and care provided SC (but not with regard to the allegation that he failed to sign the chart after administering medication), LV (but not with regard to the allegation that he failed to sign the chart after administering injections), SG (but not with regard to the allegation that he failed to sign the chart or document the placement of the IV), DM, HR, SMG (but not with regard to the allegations that he failed to send cultures for analysis and failed to generate a medical record on May 30, 2014), and MT for the reasons explained in Factual Findings 144, 146, 147, 151, 155, 157, and 161. Cause for discipline based on his allegedly engaging in repeated negligent acts with regard to the treatment and care provided DN and WL was not established the reasons explained in Factual Findings 82 through 85.

#### AIDING/ABETTING UNLICENSED PRACTICE OF MEDICINE

175. Complainant established that cause exists to discipline respondent's physician's and surgeon's certificate also for aiding/abetting the unlicensed practice of medicine with regard to the treatment and care provided MH for the reasons explained in Factual Finding 154. Cause for discipline based on his allegedly aiding/abetting the unlicensed practice of medicine with regard to the treatment and care provided DN was not established for the reasons explained in Factual Findings 82 and 83.

#### FAILURE TO MAINTAIN ADEQUATE AND ACCURATE MEDICAL RECORDS

176. Complainant established that cause exists to discipline respondent's physician's and surgeon's certificate for failing to maintain adequate and accurate records of the treatment and care provided SC, LV, SG, AJ, DM, SMG, and MT for the reasons explained in Factual Findings 144, 146, 147, 150, 151, 157, and 161. Cause for discipline based on his allegedly failing to maintain adequate and accurate records of the treatment and care provided DN was not established for the reasons explained in Factual Findings 82 and 83.

#### CLEARLY EXCESSIVE TREATMENT

177. Complainant established that cause exists to discipline respondent's physician's and surgeon's certificate also for repeatedly providing clearly excessive treatment for the reasons explained in Factual Finding 165.

#### DISHONEST OR CORRUPT ACTS DURING BOARD INTERVIEW

178. Complainant established that cause exists to discipline respondent's physicians and surgeon's certificate also for committing a dishonest or corrupt act when asked during a Board interview whether his Tennessee medical license has ever been disciplined for the

reasons explained in Factual Finding 167. Cause for discipline based on his allegedly committing a dishonest or corrupt act during a Board interview when he represented himself to be an "intensivist" and explained SG's mother voluntarily paid 20 percent of the total bill was not established for the reasons explained in Factual Findings 168 and 169.

## LEGAL CONCLUSIONS

### *Applicable Burden/Standard of Proof*

1. Complainant has the burden of proving the causes for discipline alleged in the Third Amended Accusation, and she must do so by clear and convincing evidence to a reasonable certainty. (*Daniels v. Department of Motor Vehicles* (1983) 33 Cal.3d 532, 536 ["When an administrative agency initiates an action to suspend or revoke a license, the burden of proving the facts necessary to support the action rests with the agency making the allegation"]; *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856 [the standard of proof applicable to proceedings for the discipline of professional licenses is clear and convincing evidence to a reasonable certainty].) "The courts have defined clear and convincing evidence as evidence which is so clear as to leave no substantial doubt and as sufficiently strong to command the unhesitating assent of every reasonable mind. [Citations.] It has been said that a preponderance calls for probability, while clear and convincing proof demands a *high probability* [citations]." (*In re Terry D.* (1978) 83 Cal.App.3d 890, 899; italics original.)

### *Applicable Law*

2. Business and Professions Code section 2069, subdivision (a)(1), provides:

Notwithstanding any other law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist. A medical assistant may also perform all these tasks and services upon the specific authorization of a physician assistant, a nurse practitioner, or a certified nurse-midwife.

3. "Specific authorization" is defined as follows:

"Specific authorization" means a specific written order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed on the patient, which shall be placed in the patient's medical record, or a

standing order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record.

4. A holder of a professional license cannot shield his license from discipline by conducting business through employees. (*Arenstein v. California State Board of Pharmacy* (1968) 265 Cal.App.2d 179, 192-193.) The holder of a professional license "is responsible for the acts of his agents or employees done in the course of his business in the operation of the license." (*Id.* at p. 192; *Eisenberg v. Myers* (1983) 148 Cal.App.3d 814 [affirming judgment denying petition for writ of administrative mandate seeking to vacate administrative decision placing physician's Medi-Cal provider certificates on probation based on his office manager's submission of fraudulent billings].)

#### *Cause for Discipline*

5. The Board is required to take action against any physician and surgeon who has engaged in unprofessional conduct. (Bus. & Prof. Code, § 2234.) Cause exists to discipline respondent's physician's and surgeon's certificate pursuant to Business and Professions Code section 2234 for engaging in general unprofessional conduct for the reasons explained in Factual Findings 144, 147, and 171.

6. "Unprofessional conduct" includes gross negligence. (Bus. & Prof. Code, § 2234, subd. (b).) "Gross negligence" is the "want of even scant care or [an] extreme departure from the ordinary standard of conduct, but not necessarily both." (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 197.) Cause exists to discipline respondent's physician's and surgeon's certificate pursuant to Business and Professions Code section 2234, subdivision (b), for committing gross negligence as explained in Factual Findings 144, 146, 147, 155, 157, 161, and 170.

7. "Unprofessional conduct" includes repeated acts of negligence. (Bus. & Prof. Code, § 2234, subd. (c).) "To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts." (*Ibid.*) Cause exists to discipline respondent's physician's and surgeon's certificate pursuant to Business and Professions Code section 2234, subdivision (c), for committing repeated acts of negligence as explained in Factual Findings 144, 146, 147, 151, 155, 157, 161, and 174.

8. "Unprofessional conduct" includes "the commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of the physician and surgeon." (Bus. & Prof. Code, § 2234, subd. (e).) Cause exists to discipline respondent's physician's and surgeon's certificate pursuant to Business and

Professions Code section 2234, subdivision (e), for committing a substantially related dishonest or corrupt act as explained in Factual Findings 147, 161, 162, 167, 172, and 178.

9. Business and Professions Code section 732, subdivision (a), provides, in part: “a physician and surgeon . . . shall refund any amount that a patient has paid for services rendered that has subsequently been paid to the physician and surgeon . . . by a third-party payor and that constitutes a duplicate payment.” If the patient requests a refund, the refund must be provided within 30 days of the earlier of the following: 1) the request, if the duplicate payment has been received; or 2) receipt of the duplicate payment, if the duplicate payment has not been received. (Bus. & Prof. Code, § 732, subd. (a)(1).) If no refund has been requested, the physician and surgeon must notify the patient of the duplicate payment “within 90 days of the date the physician and surgeon . . . knows, or should have known, of the receipt of the duplicate payment,” and the refund must be provided within 30 days of such notice “unless the patient requests that a credit balance be retained.” (Bus. & Prof. Code, § 732, subd. (a)(2).) The failure to comply with Business and Professions Code section 732, subdivision (a), “shall constitute unprofessional conduct.” (Bus. & Prof. Code, § 732, subd. (b).) Cause exists to discipline respondent’s physician’s and surgeon’s license pursuant to Business and Professions Code section 2234, as that statute relates to Business and Professions Code section 732, subdivision (b), based on respondent’s failure to timely refund a duplicate payment as explained in Factual Findings 147, 152, and 173.

10. Aiding or abetting the unlicensed practice of medicine constitutes unprofessional conduct. (Bus. & Prof. Code, § 2264.) Cause exists to discipline respondent’s physician’s and surgeon’s certificate pursuant to Business and Professions Code section 2234, as that statute relates to Business and Professions Code section 2264, for aiding and abetting the unlicensed practice of medicine as explained in Factual Findings 154 and 175.<sup>7</sup>

11. “The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.” (Bus. & Prof. Code, § 2266.) Cause exists to discipline respondent’s physician’s and surgeon’s certificate pursuant to Business and Professions Code section 2234, as that statute relates to Business and Professions Code section 2266, for failing to maintain adequate and accurate records as explained in Factual Findings 144, 146, 147, 150, 151, 157, 161, and 176.

12. “Repeated acts of clearly excessive . . . furnishing . . . of . . . treatment” constitutes unprofessional conduct.” (Bus. & Prof. Code, § 725, subd. (a).) Cause exists to discipline respondent’s physician’s and surgeon’s certificate pursuant to Business and

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<sup>7</sup> Complainant also alleged cause for discipline pursuant to Business and Professions Code section 2052. However, that statute does not specify any conduct for which discipline may be imposed, but rather criminalizes the aiding or abetting of the unlicensed practice of medicine.

Professions Code section 2234, as that statute relates to Business and Professions Code section 725, subdivision (a), for engaging in repeated acts of clearly excessive furnishing of treatment as explained in Factual Findings 165 and 177.

### *Appropriate Discipline*

13. The appellate court in *Furnish v. Board of Medical Examiners* (1957) 149 Cal.App.2d 326, said the following about the discipline of a physician's and surgeon's certificate:

The revocation or suspension of a license is not penal, but rather, the Legislature has provided for such to protect the life, health and welfare of the people at large and to set up a plan whereby those who practice medicine will have the qualifications which will prevent, as far as possible, the evils which could result from ignorance or incompetency or a lack of honesty and integrity.

(*Id.*, at p. 331.)

14. It must be determined whether the protection of public health, safety, and welfare require the revocation, suspension, or restriction of respondent's physician's and surgeon's certificate in light of his numerous violations of the Medical Practice Act. The Board has adopted disciplinary guidelines entitled "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (12th Edition/2016) to help make such determination. (Cal. Code Regs., tit. 16, § 1361.)

15. The Board's highest priority when exercising its disciplinary authority is protection of the public. (Bus. & Prof. Code, § 2229, subd. (a).) And "wherever possible," the Board shall impose discipline "that is calculated to aid in the rehabilitation of the licensee, or where . . . restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence." (Bus. & Prof. Code, § 2229, subd. (b).) But "where rehabilitation and protection are inconsistent, protection shall be paramount." (Bus. & Prof. Code, § 2229, subd. (c).)

16. The Disciplinary Guidelines recommend a range of discipline from five years' probation to revocation for the violations of the Medical Practice Act respondent committed, except for dishonesty and the failure to refund a duplicate payment. The recommended discipline for engaging in a dishonest or corrupt act "substantially related to the qualifications, functions or duties of a physician and surgeon and arising from or occurring

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during patient care, treatment, or management or billing” ranges from one-year suspension and a minimum of seven years’ probation, at the low end, to revocation, at the high end.<sup>8</sup>

17. Respondent did not introduce any persuasive evidence of his continued ability to perform the duties of a physician and surgeon in a manner consistent with public health, safety, and welfare. Those of his character witnesses who understood why they were asked to testify about his character had too little knowledge of the specific allegations in the Third Amended Accusation for their opinions to be given much weight. (See *Seide v. Committee of Bar Examiners of the State Bar of California* (1989) 49 Cal.3d 933, 940 [the opinions of witnesses unfamiliar with the nature and the extent of allegations of wrongdoing are entitled to less weight].)

18. The substance of respondent’s statements to Ms. Sanchez-Bartunek and his subsequent hearing testimony, his demeanor while testifying, and the manner in which he testified demonstrated little insight into his wrongdoing. When asked whether he had any responsibility for ensuring his patients were accurately billed for the treatment and services he provided, he explained:

I - I cannot - I cannot make sure that something’s accurate I don’t understand. I don’t understand coding. I’m not a coder. I don’t study terminologies. I don’t know the terms. Everything’s numbers. If you look at the - the - the new coding has come its numbers. I didn’t go to school for that.

I refuse to even learn it. I’m not good at it, that’s why we took back - the billing company is taking percentages of our fee.

He further explained:

I told the Medicine [*sic*] Board that I would rather be a garbage collector than fraudulently indulge in billing. I am not a biller. I said that. I would rather be a garbage collector than be anything that is not proper and correct.

Yet the evidence established respondent overcharged multiple patients.

19. When discussing at hearing the completion of patients’ medical charts, respondent explained he sees 50 patients a day, “sometimes more.” “We’ve seen as much as 75.” Regarding the completion of patients’ medical charts, he said, “Well, I usually, at the

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<sup>8</sup> There is no recommended discipline for failing to timely refund a duplicate payment. But given the similarity in nature of that conduct and committing a substantially related dishonest or corrupt act arising from or occurring during patient care, treatment, management or billing, the recommended range for the latter conduct is used for the former.

end of the day, if I'm not totally, completely wiped out, exhausted, I will address all my records that same day." But he also stated,

Sometimes -- it depends on how soon. A lot of time, when we see a patient, by the time they get to coding it -- in the past, sometimes, a month. Sometimes a month and a half. But, usually, in the space of about a month, two months max.

He further explained, "The billers will stack unfinished or incomplete medical records which they couldn't code or bill. They leave it in a pile. And when I have time, I'll complete it." "In fact, as I speak to you, I probably have about 200 of them sitting in my office right now."

20. And when asked how he could remember what happened with a particular patient with sufficient detail to complete the patient's medical chart after the fact, respondent explained:

That's why I'm the professional. This is what I do for a living. I'm consumed by it. It's all I do. And training over the years, you're good at it.

But at hearing, respondent could not recall whether MT's bee sting was to the palm-side or the back of his hand, and he could not tell from reviewing the medical chart.

21. During the Board's investigation, respondent made the following statement when asked whether he was ever under investigation by the Tennessee Board of Medical Examiners:

I filled the form, there was no question from the board and as far as I know they never investigated, whatever. Anyway I've been, they investigate me, because I defied the - the standards that you expect of someone like me. Alright? I don't conform to those things. Like I said, I evolve second fiddle. I will not tolerate it from anyone, or by any institution where they may be.

The above statement was read to him at hearing, and he was given an opportunity to explain it. First, he said he did not "understand it at all," and hypothesized "maybe they didn't hear me right." Then, he claimed, "Mistyped. Maybe my accent, they typed it wrong. Or the record got it wrong. Didn't hear what I say. Don't even understand gibberish, as far as I'm concerned, what you just read."

22. But when an audio recording of that statement was played at hearing, respondent did not deny that it was his voice on the recording. His explanation of his statement was nonsensical:

What I meant is what you just played, and that is what I'm going to replay to you. What you just played.

And when asked whether he had a better explanation of his statement, respondent claimed the "transcription was wrong." It was not.

### *Conclusion*

23. Considering all relevant evidence, respondent failed to introduce sufficient evidence demonstrating his continued ability to perform the duties of a physician and surgeon in a manner consistent with public health, safety, and welfare. His incorrigibility, haughtiness, and complete lack of candor throughout the Board's investigation and the hearing demonstrated the unlikelihood of his abiding by any restrictions imposed by the Board on his physician's and surgeon's certificate, thereby making him an unsuitable candidate for a probationary license. Respondent's physician's and surgeon's certificate must be revoked.

### ORDER

Physician's and Surgeon's Certificate Number A 43177 issued to respondent Ifeatu Ekelem, M.D., on October 6, 1986, is REVOKED.

DATED: January 12, 2018

DocuSigned by:

*Coren D. Wong*

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COREN D. WONG

Administrative Law Judge

Office of Administrative Hearings

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FILED  
STATE OF CALIFORNIA  
MEDICAL BOARD OF CALIFORNIA  
SACRAMENTO *Mar. 1* 20 *17*  
BY *[Signature]* ANALYST

8  
9 **BEFORE THE**  
**MEDICAL BOARD OF CALIFORNIA**  
10 **DEPARTMENT OF CONSUMER AFFAIRS**  
**STATE OF CALIFORNIA**

11 In the Matter of the Third Amended Accusation  
12 Against:

13 **IFEATU EKELEM, M.D.**  
5261 E. Kings Canyon Road, #107  
14 Fresno, CA 93727

15 Physician's and Surgeon's Certificate No. A 43177

16 Respondent.  
17

Case No. 08-2010-205606

OAH No. 2012100045

**THIRD AMENDED ACCUSATION**

18  
19 Complainant alleges:

20 **PARTIES**

21 1. Kimberly Kirchmeyer (Complainant) brings this Third Amended Accusation solely in  
22 her official capacity as the Executive Director of the Medical Board of California, Department of  
23 Consumer Affairs (Board).

24 2. On or about October 6, 1986, the Medical Board of California issued Physician's and  
25 Surgeon's Certificate Number A 43177 to Ifeatu Ekelem, M.D. (Respondent). The Physician's  
26 and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought  
27 herein and will expire on December 31, 2015, unless renewed.

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## JURISDICTION

3. This Third Amended Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

1       "(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the  
2 violation of, or conspiring to violate any provision of this chapter.

3       "(b) Gross negligence.

4       "(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or  
5 omissions. An initial negligent act or omission followed by a separate and distinct departure from  
6 the applicable standard of care shall constitute repeated negligent acts.

7       "(1) An initial negligent diagnosis followed by an act or omission medically appropriate  
8 for that negligent diagnosis of the patient shall constitute a single negligent act.

9       "(2) When the standard of care requires a change in the diagnosis, act, or omission that  
10 constitutes the negligent act described in paragraph (1), including, but not limited to, a  
11 reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the  
12 applicable standard of care, each departure constitutes a separate and distinct breach of the  
13 standard of care.

14       "(d) Incompetence.

15       "(e) The commission of any act involving dishonesty or corruption which is substantially  
16 related to the qualifications, functions, or duties of a physician and surgeon.

17       "(f) Any action or conduct which would have warranted the denial of a certificate.

18       "(g) The practice of medicine from this state into another state or country without meeting  
19 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not  
20 apply to this subdivision. This subdivision shall become operative upon the implementation of the  
21 proposed registration program described in Section 2052.5.

22       "(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and  
23 participate in an interview by the board. This subdivision shall only apply to a certificate holder  
24 who is the subject of an investigation by the board."

25       6.     Section 2264 of the Code states:

26       AThe employing, directly or indirectly, the aiding, or the abetting of any unlicensed person  
27 or any suspended, revoked, or unlicensed practitioner to engage in the practice of medicine or any

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1 other mode of treating the sick or afflicted which requires a license to practice constitutes  
2 unprofessional conduct.@

3 7. Section 2052 of the Code states:

4 "(a) Notwithstanding Section 146, any person who practices or attempts to practice, or who  
5 advertises or holds himself or herself out as practicing, any system or mode of treating the sick or  
6 afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment,  
7 blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition  
8 of any person, without having at the time of so doing a valid, unrevoked, or unsuspended  
9 certificate as provided in this chapter [Chapter 5, the Medical Practice Act], or without being  
10 authorized to perform the act pursuant to a certificate obtained in accordance with some other  
11 provision of law, is guilty of a public offense, punishable by a fine not exceeding ten thousand  
12 dollars (\$10,000), by imprisonment in the state prison, by imprisonment in a county jail not  
13 exceeding one year, or by both the fine and either imprisonment.

14 "(b) Any person who conspires with or aids or abets another to commit any act described in  
15 subdivision (a) is guilty of a public offense, subject to the punishment described in that  
16 subdivision.

17 "(c) The remedy provided in this section shall not preclude any other remedy provided by  
18 law."

19 8. Section 2266 of the Code states: AThe failure of a physician and surgeon to maintain  
20 adequate and accurate records relating to the provision of services to their patients constitutes  
21 unprofessional conduct.@

22 9. Section 725 of the Code states:

23 "(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering  
24 of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated  
25 acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of  
26 the community of licensees is unprofessional conduct for a physician and surgeon, dentist,  
27 podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language  
28 pathologist, or audiologist.

1       "(b) Any person who engages in repeated acts of clearly excessive prescribing or  
2 administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of  
3 not less than one hundred dollars (\$100) nor more than six hundred dollars (\$600), or by  
4 imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and  
5 imprisonment.

6       "(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or  
7 administering dangerous drugs or prescription controlled substances shall not be subject to  
8 disciplinary action or prosecution under this section.

9       "(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section  
10 for treating intractable pain in compliance with Section 2241.5."

11       10. Section 732 of the Code states:

12       "(a) A physician and surgeon and a dentist shall refund any amount that a patient has paid  
13 for services rendered that has subsequently been paid to the physician and surgeon or dentist by a  
14 third-party payor and that constitutes a duplicate payment. The refund shall be made as follows:

15       "(1) If the patient requests a refund, within 30 days following the request from that patient  
16 for a refund if the duplicate payment has been received, or within 30 days of receipt of the  
17 duplicate payment if the duplicate payment has not been received.

18       "(2) If the patient does not request a refund, within 90 days of the date the physician and  
19 surgeon or dentist knows, or should have known, of the receipt of the duplicate payment, the  
20 physician and surgeon or dentist shall notify the patient of the duplicate payment, and the  
21 duplicate payment shall be refunded within 30 days unless the patient requests that a credit  
22 balance be retained.

23       "(b) Violation of this section shall constitute unprofessional conduct. Disciplinary  
24 proceedings shall be conducted in accordance with the Medical Practice Act (Chapter 5  
25 (commencing with Section 2000)) or the Dental Practice Act (Chapter 4) (commencing with  
26 Section 1600)), as applicable."

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**FIRST CAUSE FOR DISCIPLINE**  
**(Gross Negligence - Patient S.C.)**  
**(Bus. & Prof. Code § 2234(b))**

11. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that his care and treatment of patient S.C.<sup>1</sup> constitutes gross negligence. The circumstances are as follows:

12. Respondent is the proprietor and medical director of Impact Medical Group, an urgent care clinic that is open 24 hours a day, seven days a week with two locations in the Fresno area. There is no physician on-site 24 hours per day, seven days a week at Impact Medical, but Respondent is available to provide treatment within thirty minutes. Additionally, Respondent employs a part-time physician, two nurse practitioners, one physician assistant, medical assistants, and billing staff.

13. On or about January 1, 2010, patient S.C. was 63 years-old when she presented at Impact Medical with symptoms of diarrhea and vomiting for several days with the diarrhea worsening and progressing to bleeding from the rectum. S.C. further reported she was suffering pain in the abdomen and headache. Respondent examined S.C., documenting the chief complaint in the medical chart as "nausea, vomiting, diarrhea since Monday, today no vomiting, since last night rectal bleeding." The medical chart records the physical examination as "bloody anus," "abdomen – mild discomfort on palpation." Respondent did not examine S.C.'s stool or perform a rectal examination. Respondent documented medications as "see list," as S.C. had provided a typed list of her medical history, medications, and allergies; S.C.'s medical history included diverticulitis in 2008. Respondent diagnosed S.C. with "severe/moderate dehydration secondary to [acute gastroenteritis]/dysentery." Respondent documented treatment of S.C. as 3 liters of normal saline intravenously over an approximately three-hour period followed by 2 g Rocephin intravenously. The medical record fails to identify who administered medication to S.C. and made other entries in the chart. Respondent did not reassess S.C. between fluid boluses and did

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<sup>1</sup> Patient initials are used throughout this pleading to protect patient privacy.

1 not complete an IV log. Respondent discharged S.C. with instructions to follow-up at CVS  
2 Herndon Millbourne and provided her with prescriptions.

3 14. A different copy of S.C.'s medical record states that the chief complaint was "bloody  
4 stools x 3 days." The physical examination is more elaborate, including "cold clammy, mildly  
5 febrile, moderately dehydrated, mild sunken eyes, chest clear clinically. This second copy of the  
6 chart includes an additional notation written in a different pen that S.C. received a fourth liter of  
7 normal saline. The discharge instructions state, "follow up with PCP ASAP for possible stool  
8 culture, chem panel, fluid advice, if get worse – rush to ER."

9 15. Respondent's actions constitute gross negligence and subject him to discipline within  
10 the meaning of Code section 2234, subdivision (b), in that Respondent's administration of 4 liters  
11 of fluid over a three-hour window without medical justification, assessment between fluid  
12 boluses, or checking labs constitutes an extreme departure from the standard of care.

13 **SECOND CAUSE FOR DISCIPLINE**  
14 **(Dishonesty/Corruption - Patient S.C.)**  
15 **(Bus. & Prof. Code § 2234(e))**

16 16. Respondent is subject to disciplinary action under Code section 2234, subdivision (e),  
17 in that Respondent misrepresented his medical credentials. The circumstances are as follows:

18 17. Complainant realleges paragraphs 11-15 above, and incorporates them by reference  
19 as if fully set forth herein.

20 18. During her urgent care visit at Impact Medical, S.C. asked Respondent about his  
21 medical training. Respondent told S.C. that the medical school he attended is closed but that he  
22 was trained in emergency medicine and critical care. Respondent's training was not in  
23 emergency medicine or critical care.

24 19. The day following her visit at Impact Medical, S.C. called Impact Medical and asked  
25 if Respondent is board-certified. S.C. was told that Respondent is board-certified in Family  
26 Medicine. S.C.'s daughter then called Impact Medical and was told that Respondent is board-  
27 certified in Pediatrics. Respondent is not board-certified in any specialty.

28 20. Respondent's conduct of misrepresenting his medical credentials to S.C. constitutes  
dishonest conduct within the meaning of Code section 2234, subdivision (e).

**THIRD CAUSE FOR DISCIPLINE**  
**(General Unprofessional Conduct - Patient S.C.)**  
**(Bus. & Prof. Code § 2234)**

21. Respondent is subject to disciplinary action under Code section 2234 in that Respondent misrepresented his credentials to S.C., that he was an approved Blue Shield provider, and that S.C. was required to pay 20% of the costs of saline even though her insurance plan only required payment of the appropriate co-pay. The circumstances are as follows:

22. Complainant realleges paragraphs 11-20 above, and incorporates them by reference as if fully set forth herein.

23. On or about January 1, 2010, S.C. called Impact Medical and confirmed that it took S.C.'s medical insurance, i.e., Blue Shield HMO and MediCal. Respondent was not an approved provider for Blue Shield.

24. Upon arriving at Impact Medical, S.C. paid the required Blue Shield co-pay of \$50 for urgent care visits. S.C. was not told that there might be additional charges for any services rendered during the visit.

25. After receiving four bags of saline intravenously at Impact Medical for dehydration, S.C. was given a bill for \$640; S.C. was informed that she was responsible for 20% of the cost of the saline, which cost \$3,200 (\$800 per bag). S.C. told Respondent's staff that her insurance policy did not require her to pay anything above her co-pay. Respondent's staff told S.C. that it was the policy of Impact Medical that she pay 20% of the cost of the saline and S.C. was required to pay the bill. S.C. paid the \$640 charge. Respondent did not reimburse S.C. until July 29, 2011, approximately a year and a half later.

26. Respondent's conduct of misrepresenting his medical credentials that he is an approved Blue Shield provider, and that S.C. was required to pay 20% of provided services constitutes unprofessional conduct within the meaning of Code section 2234.

**FOURTH CAUSE FOR DISCIPLINE**  
**(Failure to Refund Overpayment - Patient S.C.)**  
**(Bus. & Prof. Code § 732)**

27. Complainant realleges paragraphs 11-26 above, and incorporates them by reference as if fully set forth herein.

1        28. Respondent is subject to disciplinary action under Code section 732 in that  
2 Respondent required S.C. to pay a \$50 co-pay and 20% of the costs of saline even though her  
3 insurance only required payment of the appropriate co-pay and Respondent waited approximately  
4 a year and half before reimbursing S.C.

5                                    **FIFTH CAUSE FOR DISCIPLINE**  
6                                    **(Repeated Negligent Acts-Patient S.C.)**  
7                                    **(Bus. & Prof. Code § 2234(c))**

8        29. Complainant realleges paragraphs 11-28 above, and incorporates them by reference  
9 as if fully set forth herein.

10       30. Respondent is subject to disciplinary action under Code section 2234, subdivision (c),  
11 in that:

12       a. Respondent's failure to obtain a complete history, obtain stool cultures or perform a  
13 rectal examination, and complete an IV log for patient S.C. are departures from the standard of  
14 care;

15       b. Respondent's failure to sign the chart when administering the medication to S.C. or  
16 making entries in S.C.'s chart is a departure from the standard of care;

17       c. Respondent's administration of 4 liters of fluid to S.C. over three hours without  
18 medical justification or assessment between fluid boluses is a departure from the standard of care;

19       d. Respondent's failure to repeat S.C.'s vital signs after the administration of IV fluids is  
20 a departure from the standard of care;

21       e. Respondent's diagnosing S.C. with gastroenteritis without considering a broader  
22 differential diagnosis is a departure from the standard of care;

23       f. Respondent's administration of Rocephin to S.C. for the wrong indication is a  
24 departure from the standard of care; and

25       g. Respondent's altering of S.C.'s medical records after S.C. left is a departure from the  
26 standard of care.

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**SIXTH CAUSE FOR DISCIPLINE**

**(Gross Negligence - Patient L.V.)**

**(Bus. & Prof. Code § 2234(b))**

31. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that his care and treatment of patient L.V. constitutes gross negligence. The circumstances are as follows:-

32. On or about July 8, 2010, patient L.V. was 32 years old when she presented to Impact Medical. L.V. presented at the clinic with flu symptoms for more than 24 hours, including fever, cough, sinus congestion, headache, and body aches. Respondent examined L.V., noting on the medical chart that the chief complaint was "flu symptoms." Respondent left the history part of the chart blank. Under physical exam, Respondent documented all vital signs except respiratory rate and wrote "ill, not in distress, rales/ronchi, heart regular rate and rhythm no murmur, HEENT: sinus tender." Respondent did not obtain a chest x-ray of L.V. Respondent diagnosed L.V. with pneumonitis and sinusitis; Respondent did not diagnose L.V. with asthma, emphysema or reactive airway to indicate the use of a steroid. Respondent's plan was intramuscular Rocephin 1g and intramuscular Kenalog 40 mg. L.V. received two shots; the area of the chart marked "shot" was left blank and it was not documented who administered the shots. Respondent's discharge instructions were "must follow up with primary care physician as soon as possible" and L.V. was given prescriptions for prednisone 40 mg a day for 5 days, Z-Pak Pro Air Inhaler, and Allegra D.

33. When the Kenalog shot was administered to patient L.V., it was injected into the subcutaneous fat instead of the muscle. Thereafter, L.V. developed lipodystrophy (a fat abnormality visibly apparent on L.V.'s arm as a dent at the injection site).

34. Respondent's actions constitute gross negligence and subject him to discipline within the meaning of Code section 2234, subdivision(b), in that:

a. Respondent's failure to document any history in L.V.'s medical chart constitutes an extreme departure from the standard of care;

b. Respondent's administration of Rocephin for a pulmonary infection without obtaining a chest x-ray constitutes an extreme departure from the standard of care; and

1 c. Respondent's administration of Kenalog for pnuemonitis or sinusitis constitutes an  
2 extreme departure from the standard of care.

3 **SEVENTH CAUSE FOR DISCIPLINE**  
4 **(Repeated Negligent Acts-Patient L.V.)**  
5 **(Bus. & Prof. Code § 2234(c))**

6 35. Complainant realleges paragraphs 31-34 above, and incorporates them by reference  
7 as if fully set forth herein.

8 36. Respondent is subject to disciplinary action under Code section 2234, subdivision (c),  
9 in that:

10 a. Respondent's failure to document patient L.V.'s history, past medical history, and  
11 respiratory rate in the medical chart is a departure from the standard of care;

12 b. Respondent's failure to sign L.V.'s medical chart when administering the  
13 intramuscular injections is a departure from the standard of care;

14 c. Respondent's administration of Rocephin to L.V. for a pulmonary infection without  
15 obtaining a chest x-ray is a departure from the standard of care;

16 d. Respondent's administration of Kenalog to L.V. for pneumonitis or sinusitis is a  
17 departure from the standard of care; and

18 e. Respondent's, or his medical assistant's, failure to administer the Kenalog injection  
19 into the deep muscle of patient L.V.'s arm is a departure from the standard of care.

20 **EIGHTH CAUSE FOR DISCIPLINE**  
21 **(Gross Negligence - Patient S.G.)**  
22 **(Bus. & Prof. Code § 2234(b))**

23 37. Respondent is subject to disciplinary action under Code section 2234, subdivision (b),  
24 in that his care and treatment of patient S.G. constitutes gross negligence. The circumstances are  
25 as follows:

26 38. On or about September 5, 2010, patient S.G. was 4 years-old when he presented to  
27 the Impact Medical with symptoms of vomiting, dehydration, weakness, and labored breathing.  
28 Respondent examined S.G. and documented the history on the medical chart as "multiple  
episodes of vomiting x 12 in day; now tired, not moving or responding as well. Also seems to be  
breathing hard. No diarrhea. No fever." Respondent did not record a past medical history.

1 Under physical exam, Respondent documented all vital signs except respiratory rate and wrote  
2 "ill, moderately dehydrated child, sunken eyes, decreased skin turgor, tachypnea, chest clear  
3 clinically, heart regular rate and rhythm with no murmur; abdomen flat, soft, non-tender;  
4 extremities, full range of motion." Respondent noted under "S" (subjective) that S.G. "seems to  
5 be breathing hard" and further noted on the chart that S.G. was "not moving or responding well."  
6 Respondent did not document S.G.'s level of alertness. Respondent did not obtain a chest x-ray.  
7 Respondent diagnosed S.G. with "moderate dehydration due to acute gastroenteritis."

8 39. Respondent treated S.G. with 2 liters of intravenous .45 normal saline over an  
9 approximately three-hour period and an injection of 12.5 mg of Phenergan. The area of the  
10 medical chart labeled "shot" reflects administration of the medication, but there is no signature or  
11 initial for the medication administration. In administering intravenous fluids, Respondent began  
12 an "IV In Progress" form with a start time of 2:00 p.m. Respondent documented S.G.'s vitals at  
13 2:09 and 2:44; Respondent did not document S.G.'s vitals at 3:00 p.m. and the IV In Progress  
14 form was not completed. There is no documentation of who started S.G.'s IV and where it was  
15 placed.

16 40. Respondent's actions constitute gross negligence and subject him to discipline within  
17 the meaning of Code section 2234, subdivision (b), in that:

18 a. Respondent's administration of an excessive amount of fluids endangered S.G.'s life  
19 and constitutes an extreme departure from the standard of care; and

20 b. Respondent's failure to perform a complete medical work up of S.G. or alternatively  
21 refer S.G. to a hospital constitutes an extreme departure from the standard of care.

#### 22 **NINTH CAUSE FOR DISCIPLINE**

23 **(Dishonesty - Patient S.G.)**  
24 **(Bus. & Prof. Code § 2234(e))**

25 41. Respondent is subject to disciplinary action under Code section 2234, subdivision (e),  
26 in that Respondent misrepresented the terms of payment required by S.G.'s medical insurance at  
27 Impact Medical. The circumstances are as follows:

28 42. Complainant realleges paragraphs 37-40 above, and incorporates them by reference  
as if fully set forth herein.

1        43. Impact Medical required S.G.'s mother, M.G., to pay a \$50 co-pay even though her  
2 insurance card specified a \$15 co-pay.

3        44. After receiving treatment and on their way out of the clinic, Respondent's medical  
4 assistant stopped M.G. and S.G. and informed them that the balance due was \$326 and asked for  
5 payment in the form of cash, credit card, or check. M.G. asked why there was a balance owed  
6 since Impact Medical was in M.G.'s insurance network and S.G.'s insurance covers 90% with a  
7 \$15 co-pay. Respondent's medical assistant informed M.G. that her insurance only covers 80%,  
8 and M.G. had to pay the balance. M.G. informed the medical assistant that she would not have  
9 the funds until payday and she had not brought her husband's checkbook. The medical assistant  
10 asked M.G. to go home and return with the checkbook. M.G. informed the medical assistant that  
11 she lived in another city and was not going to drive home to get the checkbook. The medical  
12 assistant then asked that M.G. get her husband's credit card number. M.G. called her husband  
13 and had him pay over the phone with a credit card.

14        45. On or about September 6, 2010, M.G. called her insurance company regarding the  
15 copayment. M.G. was told that she was correct about her insurance coverage and should not have  
16 been required to pay the additional amount when a claim had not even been processed yet.

17        46. After numerous conversations with various staff of Respondent's, Respondent's staff  
18 told M.G. that she was entitled to a refund because Respondent had received payment from both  
19 M.G. and M.G.'s insurance company. M.G. was subsequently told that Respondent would not  
20 approve a reimbursement to M.G. because Respondent was not satisfied with the payment he  
21 received from M.G.'s insurance company. Respondent did not reimburse M.G. until  
22 approximately July 29, 2011, roughly a year later.

23        47. Respondent's conduct of misrepresenting the terms of payment required by S.G.'s  
24 insurance constitutes dishonesty within the meaning of Code section 2234, subdivision (e).

25        ///

26        ///

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**TENTH CAUSE FOR DISCIPLINE**  
**(General Unprofessional Conduct – Patient S.G.)**  
**(Bus. & Prof. Code § 2234)**

48. Respondent is subject to disciplinary action under Code section 2234 in that he misrepresented the terms of payment required by S.G.'s medical insurance at Impact Medical and used derogatory language towards M.G. The circumstances are as follows:

49. Complainant realleges paragraphs 37-47 above, and incorporates them by reference as if fully set forth herein.

50. In or around October 2010, Respondent received payment from S.G.'s insurance company in accordance with the contracted rates.

51. On or about November 4, 2010, M.G. went to Respondent's office to talk with him directly. M.G. was first told by Respondent's receptionist that Respondent refused to come and speak with M.G. M.G. then saw Respondent walking in the hallway and called out. M.G. asked Respondent why he was refusing to reimburse her money and told him that what he was doing was illegal because it was double-billing. A verbal altercation ensued between M.G. and Respondent, and Respondent called M.G. a "stupid animal" and that this was not a jungle but a professional place of business. Respondent continued to insult M.G. and instructed his receptionist to call the police.

52. Respondent did not reimburse M.G. until approximately July 29, 2011, roughly a year later.

53. Respondent's conduct of misrepresenting the terms of payment required by S.G.'s insurance, using derogatory language towards M.G., and receiving duplicate payment but refusing to issue a refund to M.G. constitutes unprofessional conduct under Code section 2234.

**ELEVENTH CAUSE FOR DISCIPLINE**  
**(Failure to Refund Overpayment, Unprofessional Conduct - Patient S.G.)**  
**(Bus. & Prof. Code §§ 732, 2234)**

54. Complainant realleges paragraphs 37-53 above, and incorporates them by reference as if fully set forth herein.

55. Respondent is subject to disciplinary action under Code sections 732 and 2234 in that Respondent required S.G. to pay a co-pay of \$50 and 20% of the costs of provided services in

contradiction of the terms of S.G.'s insurance and then failed to reimburse S.G. after receiving payment from S.G.'s insurance company.

**TWELFTH CAUSE FOR DISCIPLINE**  
**(Repeated Negligent Acts-Patient S.G.)**  
**(Bus. & Prof. Code § 2234(c))**

56. Complainant realleges paragraphs 37-55 above, and incorporates them by reference as if fully set forth herein.

57. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that:

a. Respondent's failure to document patient S.G.'s past medical history and respiratory rate in the medical chart is a departure from the standard of care;

b. Respondent's failure to sign S.G.'s chart when administering the medication or documentation of the IV placement is a departure from the standard of care;

c. Respondent's administration of an excessive amount of fluids to S.G. is a departure from the standard of care;

d. Respondent's failure to perform a complete medical work up of S.G. or alternatively refer S.G. to a hospital is a departure from the standard of care;

e. Respondent's failure to complete S.G.'s "IV In Progress form" is a departure from the standard of care; and

f. Respondent's incorrect diagnosis of gastroenteritis for S.G. is a departure from the standard of care.

**THIRTEENTH CAUSE FOR DISCIPLINE**  
**(Gross Negligence - Patient D.N.)**  
**(Bus. & Prof. 2234(b))**

58. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that his care and treatment of patient D.N. constitutes gross negligence. The circumstances are as follows:

59. On or about September 13, 2010, patient D.N. was 61 years-old when he presented at Impact Medical at 9:20 p.m. for a tetanus shot due to a cut he received on his left arm. The encounter form identifies the chief complaint as "cut left arm." The SOAP format note lists the S

1 (subjective) as "as above;" the O (objective) is "abrasion to left arm;" the A (assessment) is "left  
2 arm abrasion;" and the P (plan) is [intramuscular] tetanus .5 ml [intramuscular]" and "Neosporin  
3 [three times a day]." The chart does not include a history of the circumstances of the laceration  
4 and there is no examination of the patient or description of the wound. Past medical history and  
5 medications are not listed. D.N.'s vital signs were taken, including blood pressure of 95/72. The  
6 chart records that D.N. was given a tetanus vaccine in the left arm at 9:57 p.m. There is no  
7 signature on the form identifying who wrote the information on the chart. D.N. was billed for a  
8 medical evaluation, administration of a vaccine, and the vaccine.

9 60. Upon returning home, D.N. complained of extreme hunger and ate. D.N. then went  
10 to bed. D.N. later awoke with a racing chest and palpitations. D.N.'s wife took D.N. back to the  
11 Impact Medical, where Respondent's receptionist stated that a physician was not present and  
12 instructed D.N.'s wife to call 911.

13 61. On September 14, 2010, around 12:29 a.m. D.N. was transported by ambulance to  
14 Saint Agnes Hospital emergency room. D.N. arrived with an altered mental status, chills,  
15 diaphoresis, and hunger despite eating a large dinner. A review of D.N.'s symptoms included  
16 palpitations. D.N. had no history of diabetes; his past medical history included Parkinson's  
17 disease, gastroesophageal reflux disease, hypercholesterolemia, hernia repair, and pilonidal cyst.  
18 His physical examination was remarkable for confusion, diaphoresis, and irregular heart rate. An  
19 EKG showed atrial fibrillation at a rate of 113. A work up revealed his blood sugar was low at  
20 39, his potassium was low at 2.6, his white blood cells and blood count were normal, his thyroid  
21 studies were normal, and chest x-ray was unremarkable. D.N. was given cardizem and his heart  
22 rate slowed down and he spontaneously converted into a normal sinus rhythm. D.N.'s blood  
23 sugar improved to 125 and his mental status improved after receiving D50 glucose. D.N. was  
24 also given 40 mEq of potassium replacement. D.N. was then transferred to Fresno Community  
25 Regional Medical Center due to continuity of care issues. D.N. was then discharged home on  
26 September 15, 2010.

27 62. The Fresno Community medical records presume that the "tetanus" shot that was  
28 given to D.N. at Impact Medical was in fact insulin that resulted in hypoglycemia.

1       63. Respondent's actions constitute gross negligence and subject him to discipline within  
2 the meaning of Code section 2234, subdivision (b), in that:

3       a. Respondent's failure to take a complete history and physical of D.N. constitutes an  
4 extreme departure from the standard of care; and

5       b. Respondent's administration of insulin instead of tetanus to D.N. constitutes an  
6 extreme departure from the standard of care.

7                   **FOURTEENTH CAUSE FOR DISCIPLINE**

8                   **(Dishonesty - Patient D.N.)**  
9                   **(Bus. & Prof. Code § 2234(e))**

10       64. Complainant realleges paragraphs 58-63 above, and incorporates them by reference  
11 as if fully set forth herein.

12       65. Respondent is subject to disciplinary action under Code section 2234, subdivision (e),  
13 in that he was not honest with the Medical Board investigators regarding his care and treatment of  
14 patient D.N. Respondent told investigators that he was on the premises of Impact Medical at the  
15 time that D.N. presented for treatment, that he saw and evaluated D.N., and that D.N. rejected  
16 treatment of the laceration. Additionally, Respondent created a chart note for D.N. that implies  
17 Respondent saw and evaluated D.N. Neither Respondent nor any other physician saw D.N.

18                   **FIFTEENTH CAUSE FOR DISCIPLINE**  
19                   **(Aiding/Abetting Unlicensed Practice of Medicine,**  
20                   **Practice Without Certificate - Patient D.N.)**  
21                   **(Bus. & Prof. Code §§ 2264, 2052)**

22       66. Complainant realleges paragraphs 58-65 above, and incorporates them by reference  
23 as if fully set forth herein.

24       67. Respondent is subject to disciplinary action under Code sections 2264 and 2052 in  
25 that Respondent allowed his unlicensed medical assistant to practice medicine. The practice of  
26 medicine includes, but is not limited to, treating, diagnosing, and prescribing for any ailment,  
27 disease, injury, or condition of any person. Respondent was not present when his medical  
28 assistant saw D.N. and administered the "tetanus" shot, and Respondent did not approve the  
administration of the "tetanus" shot.

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1 **SIXTEENTH CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts-Patient D.N.)**

3 **(Bus. & Prof. Code § 2234(c))**

4 68. Complainant realleges paragraphs 58-67 above, and incorporates them by reference  
5 as if fully set forth herein.

6 69. Respondent is subject to disciplinary action under Code section 2234, subdivision (c),  
7 in that:

8 a. Respondent's failure to take a complete history and physical of patient D.N. is a  
9 departure from the standard of care;

10 b. Respondent's failure to sign the chart when administering a tetanus shot to D.N. is a  
11 departure from the standard of care;

12 c. Respondent's failure to address D.N.'s low blood pressure is a departure from the  
13 standard of care;

14 d. Respondent's billing of D.N. for medical services that were not performed is a  
15 departure from the standard of care; and

16 e. Respondent's administration of insulin instead of tetanus to D.N. is a departure from  
17 the standard of care.

18 **SEVENTEENTH CAUSE FOR DISCIPLINE**

19 **(Failure to Maintain Patient Records-**

20 **patients A.J., S.C., L.V., S.G., D.N., D.M., S.M.G)**

21 **(Bus. & Prof. Code § 2266)**

22 70. Respondent is subject to disciplinary action under Code section 2266 in that he is  
23 guilty of failure to produce and maintain an adequate and accurate record of his treatment of  
24 patient A.J. The circumstances are as follows:

25 71. On or about August 2, 2012, patient A.J. went to Impact Medical for treatment of a  
26 persistent nosebleed. A.J. was dissatisfied with the treatment she received from Respondent and  
27 she subsequently filed a consumer complaint. During the investigation into A.J.'s complaint,  
28 Respondent acknowledged that he had treated her in his urgent care clinic, but he could not  
produce the patient's medical records. The law and the standard of practice requires that a  
medical record be maintained for each patient which includes all aspects of care, including the

1 patient's complaint, physical examination, and treatment. The chart should also be signed by the  
2 treating physician. Respondent is subject to disciplinary action under Code section 2266 in that he  
3 failed to maintain a medical record for patient A.J. as required by law.

4 72. Respondent is additionally subject to disciplinary action under Code section 2266 in  
5 that he failed to maintain an adequate and accurate record of his treatment of patients S.C., L.V.,  
6 S.G., D.N, D.M., and S.M.G.

7 73. Complainant realleges and incorporates paragraphs 13, 14, 32, 38, 39, 59, 83, 102,  
8 103 and 107 (e) as though fully set forth here.

9 a. Respondent is subject to disciplinary action under Code section 2266 in that he failed  
10 to maintain adequate and accurate records in his care and treatment of patient S.C. as alleged in  
11 paragraphs 13 and 14 herein.

12 b. Respondent is subject to disciplinary action under Code section 2266 in that he failed  
13 to maintain adequate and accurate records in his care and treatment of patient L.V. as alleged in  
14 paragraph 32 herein.

15 c. Respondent is subject to disciplinary action under Code section 2266 in that he failed  
16 to maintain adequate and accurate records in his care and treatment of patient S.G. as alleged in  
17 paragraphs 38 and 39 herein.

18 d. Respondent is subject to disciplinary action under Code section 2266 in that he failed  
19 to maintain adequate and accurate records in his care and treatment of patient D.N. as alleged in  
20 paragraph 59 herein.

21 e. Respondent is subject to disciplinary action under Code section 2266 in that he failed  
22 to maintain adequate and accurate records in his care and treatment of patient D.M. as alleged in  
23 paragraph 83 herein.

24 f. Respondent is subject to disciplinary action under Code section 2266 in that he failed  
25 to maintain adequate and accurate records in his care and treatment of patient S.M.G. as alleged  
26 in paragraphs 102, 103 and 107 (e) herein.

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28 ///

1       74. Each of the failures of Respondent to maintain adequate and accurate records of his  
2 care and treatment of patients A.J., S.C., L.V., S.G., D.N, D.M., and S.M.G as alleged in  
3 paragraphs 71 through 73 constitutes a separate violation of section 2266.

4                                   **EIGHTEENTH CAUSE FOR DISCIPLINE**  
5                                   **(Repeated Negligent Acts-Patient W.L.)**  
6                                   **(Bus. & Prof. Code § 2234(c))**

7       75. Respondent is subject to disciplinary action under Code section 2234, subdivision (c),  
8 in that he is guilty of repeated negligent acts relative to his care and treatment of patient W.L.  
9 The circumstances are as follows:

10       76. Patient W.L. was a 41-year-old male who saw Respondent at Impact Medical on or  
11 about September 13, 2012. The patient was complaining of cough, chest tightness, throat  
12 problems, and wheezing.

13       77. Patient W.L. was eventually seen by Respondent's medical assistant who offered to  
14 administer an albuterol breathing treatment. The patient refused because he had not been  
15 examined by a medical professional. Patient W.L. left Respondent's clinic without receiving  
16 treatment and went to another urgent care center where he was diagnosed with pneumonia and  
17 treated.

18       78. Respondent is subject to disciplinary action under Code section 2234(c)) in that he  
19 failed to properly evaluate the patient's condition prior to attempting to authorize his medical  
20 assistant to administer treatment. Respondent's medical assistant is not sufficiently trained and  
21 licensed to determine proper therapy. Respondent's failure to properly evaluate the patient's  
22 condition prior to authorizing his medical assistant to administer treatment is a departure from the  
23 standard of care.

24                                   **NINETEENTH CAUSE FOR DISCIPLINE**  
25                                   **(Repeated Negligent Acts-Patient D.M.)**  
26                                   **(Bus. & Prof. Code § 2234(c))**

27       79. Respondent is subject to disciplinary action under Code section 2234, subdivision (c),  
28 in that he is guilty of repeated negligent acts relative to his care and treatment of patient D.M.  
The circumstances are as follows:



1        87. The physician assistant generated a chart documenting the treatment of L.S. The  
2 chart was signed by the physician assistant, and the name of a physician was written in block  
3 letters next to the signature. The physician did not sign the chart, and there is no evidence the  
4 chart was reviewed by a physician. Respondent has no written protocols governing the  
5 supervision of physician assistants.

6        88. Respondent is subject to disciplinary action under Code section 2234, subdivision (b),  
7 in that he failed to ensure proper supervision of the physician assistant who treated L.S., either by  
8 ensuring that the chart was reviewed by a physician, or by establishing written protocols  
9 governing physician assistants. Failing to ensure proper supervision of a physician assistant is an  
10 extreme departure from the standard of care.

11                    **TWENTY-FIRST CAUSE FOR DISCIPLINE**  
12                    **(Failure to Refund Overpayment, Unprofessional Conduct - Patient L.S.)**  
13                    **(Bus. & Prof. Code §§ 732, 2234)**

14        89. Complainant realleges paragraphs 85-88 above, and incorporates them by reference  
15 as if fully set forth herein.

16        90. Respondent is subject to disciplinary action under sections 732 and 2234 of the Code  
17 in that Respondent required L.S. to pay a co-pay of \$50.00 in contradiction of the terms of L.S.'s  
18 insurance, which requires a \$15.00 copayment. Respondent then failed to reimburse L.S. after  
19 repeated requests.

20                    **TWENTY-SECOND CAUSE FOR DISCIPLINE**  
21                    **(Aiding/Abetting Unlicensed Practice of Medicine,**  
22                    **Practice Without Certificate - Patient M.H.)**  
23                    **(Bus. & Prof. Code §§ 2264, 2052)**

24        91. Respondent is subject to disciplinary action under Code sections 2264 and 2052 in  
25 that Respondent allowed his unlicensed medical assistant to practice medicine. The  
26 circumstances are as follows:

27        92. Patient M.H. was a 38-year-old woman who presented to Impact Medical on or about  
28 September 5, 2014, with a complaint of cough and chest congestion for 6 days. She was seen by  
a medical assistant, who obtained vital signs and recorded a chief complaint and current  
medications. No physical examination was noted, and no signature appears on the chart

1 documenting that the patient was seen by any licensed medical professional. However, the chart  
2 indicates that a nebulizer treatment was begun at 10:33 a.m., and that at 11:20 a.m. the patient  
3 “came out of the room yelling and screaming stating that there was not a Dr. here.”

4 93. Respondent is subject to disciplinary action under Code sections 2264 and 2052 in  
5 that Respondent allowed his unlicensed medical assistant to practice medicine. The practice of  
6 medicine includes, but is not limited to, treating, diagnosing, and prescribing for any ailment,  
7 disease, injury, or condition of any person. Administering a nebulizer treatment to a patient who  
8 may have an airway compromise is a significant medical treatment that may only be initiated by a  
9 licensed person.

10 **TWENTY-THIRD CAUSE FOR DISCIPLINE**  
11 **(Gross Negligence -Patient H.R.)**  
12 **(Bus. & Prof. Code § 2234(b))**

13 94. Respondent is subject to disciplinary action under Code section 2234, subdivision (b),  
14 in that he is guilty of gross negligence relative to his care and treatment of patient H.R. The  
15 circumstances are as follows:

16 95. On or about May 20, 2014, Patient H.R. was 89 years-old when he presented to  
17 Impact Medical. H.R. had fallen, suffered a skin tear to his left elbow, and exhibited extensive  
18 bruising and swelling to his left arm and left cheek. H.R. was taken to an exam room and his  
19 vital signs were taken by a medical assistant. Respondent walked toward the room, stated “this  
20 one will take a long time,” and then walked away to see other patients. The room was prepared  
21 for suturing, and Respondent returned to the room after a period of time, and seated himself to  
22 start suturing. The patient’s girlfriend, who had accompanied him to the exam room, asked  
23 Respondent if he was going to stitch the patient’s skin, and asked that he not suture the patient as  
24 the patient was taking Coumadin<sup>2</sup>, and had thin, fragile skin which would not hold the stitches.  
25 Respondent replied by asking, “Who are you to advise me, with my level of training, what I  
26 should do?” The patient’s daughter, who was also present, asked Respondent to simply clean the  
27 wound, and she would take the patient to his primary care physician. Respondent raised his

28 <sup>2</sup> Coumadin is a brand name for warfarin, an anticoagulant widely used for the prevention  
of blood clots.

1 voice, and asked again, "Who are you to tell me what to do?" Respondent continued to berate the  
2 patient's girlfriend and daughter, and then directed his staff to call an ambulance. The patient's  
3 daughter requested that the patient's medical records be given to the ambulance personnel, and  
4 Respondent refused. The patient was taken to a local hospital, where he was kept overnight for  
5 observation, and where his wounds were dressed but not stitched.

6 96. Respondent is subject to disciplinary action under Code section 2234, subdivision (b),  
7 in that he failed to recognize and act upon a potential head injury to a patient on Coumadin.  
8 When Respondent first saw the patient, he stated "this one will take a long time." In fact, this  
9 patient should have taken no time at all, as the facial injury to an elderly patient should have  
10 alerted Respondent that he needed immediate care at an emergency department, and an  
11 ambulance should have been called immediately. Respondent's delay in calling for an ambulance  
12 is an extreme departure from the standard of care.

13 **TWENTY-FOURTH CAUSE FOR DISCIPLINE**  
14 **(Repeated Negligent Acts-Patient H.R.)**  
15 **(Bus. & Prof. Code § 2234(c))**

16 97. Complainant realleges paragraphs 94-96 above, and incorporates them by reference  
17 as if fully set forth herein.

18 98. Respondent is subject to disciplinary action under Code section 2234, subdivision (c),  
19 in that:

20 a. Respondent prepared to suture the skin tear on H.R.'s elbow. The wound was not  
21 conducive to suturing as the skin was very thin, fragile, and already torn. The treatment for such  
22 a wound would be to clean it with saline, and place a sterile dressing with wound dressing  
23 material such as xeroform. Respondent's intended treatment of the patient by suturing is a  
24 departure from the standard of care.

25 b. Respondent's failure to recognize a potential head injury in an elderly patient on  
26 Coumadin, and to immediately refer the patient to emergency care, are departures from the  
27 standard of care.

28 c. Respondent's failure to provide medical records to ambulance personnel when they  
arrived is a departure from the standard of care.

**TWENTY-FIFTH CAUSE FOR DISCIPLINE**  
**(General Unprofessional Conduct – Patient H.R.)**  
**(Bus. & Prof. Code § 2234)**

99. Complainant realleges paragraphs 94-98 above, and incorporates them by reference as if fully set forth herein.

100. Respondent is subject to disciplinary action under Code section 2234 in that he raised his voice at the patient's daughter and the patient's girlfriend, and berated them for questioning his medical treatment of the patient. Respondent's conduct constitutes unprofessional conduct within the meaning of Code section 2234.

**TWENTY-SIXTH CAUSE FOR DISCIPLINE**  
**(Gross Negligence -Patient S.M.G.)**  
**(Bus. & Prof. Code § 2234(b))**

101. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he is guilty of gross negligence relative to his care and treatment of patient S.M.G. The circumstances are as follows:

102. On or about May 20, 2014, Patient S.M.G. was 36 years-old when she presented to Impact Medical complaining of vaginal itching and malodorous discharge after unprotected sex one month prior. The patient's vital signs were taken by a medical assistant. Respondent documented a physical examination including appearance, head and neck exam, lung exam, and abdominal exam. A pelvic exam description was not documented. The patient's chart reflects only "vaginal swab was done—culture sent." Urine dip results and urine pregnancy test results were both negative. Respondent made a diagnosis of Bacterial Vaginosis and STD (sexually transmitted disease) panel necessary. "Rocephin 1 mg" was written on the patient's chart, but crossed out. Respondent prescribed doxycycline 100 mg twice daily for seven days. There is no documentation in the patient's chart that any STD panel or vaginal swab was actually sent to any lab, and any such lab results are absent from the chart.

103. On or about May 30, 2014, S.M.G. called Respondent's clinic seeking her lab results. She was told by Respondent's staff that her results were "lost." S.M.G. returned to the clinic to pick up the lab results. She was told she would need to complete new patient paperwork, since her chart had been lost. She was placed in an exam room, where she waited for approximately

1 one hour. She then stepped out into the lobby to ask how much longer she would need to wait.  
2 Respondent confronted S.M.G. and asked why she had left her exam room. S.M.G. stated that the  
3 exam room was hot, and that she was told her lab results were lost. Respondent raised his voice,  
4 and told S.M.G. she was rude and uncooperative and asked her to leave, stating in front of other  
5 patients that "you should be ashamed of yourself." S.M.G. stated that she would not leave  
6 without her lab results, at which point Respondent threatened to call the police. A medical  
7 assistant then came to the lobby and escorted S.M.G. outside.

8 104. Respondent is subject to disciplinary action under Code section 2234, subdivision (b),  
9 in that he failed to complete a pelvic examination, given S.M.G.'s complaint of vaginal discharge.  
10 A pelvic examination includes a description of the outer vaginal area; a description of discharge if  
11 present; comment on cervical motion tenderness; uterine size, shape and tenderness; and ovarian  
12 evaluation. Such an exam is critical to differentiating cervicitis versus pelvic inflammatory  
13 disease (PID). S.M.G. was treated for cervicitis with 7 days of doxycycline; however, if she  
14 exhibited cervical motion tenderness, then the appropriate diagnosis would be PID. Treatment of  
15 PID requires 14 days of antibiotics. Undertreatment of PID can result in permanent fertility  
16 problems. Respondent's failure to complete a pelvic examination in his treatment of S.M.G.  
17 represents an extreme departure from the standard of care.

18 105. Respondent is subject to disciplinary action under Code section 2234, subdivision (b),  
19 in that he failed to appropriately treat S.M.G.'s vaginal discharge. A patient with vaginal  
20 discharge and possible sexually transmitted disease requires treatment for possible gonorrhea and  
21 chlamydia. Such treatment is required regardless of whether cultures are obtained, because the  
22 two diseases often occur together and false negative results are possible. Treatment should begin  
23 before culture results are received when there is a high suspicion for infection. S.M.G. was  
24 treated appropriately for chlamydia cervicitis; however, doxycycline does not treat gonorrhea.  
25 The patient should have received Rocephin for gonorrhea. Respondent's failure to prescribe  
26 Rocephin for potential gonorrhea in patient S.M.G. is an extreme departure from the standard of  
27 care.

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**TWENTY-SEVENTH CAUSE FOR DISCIPLINE**  
**(Repeated Negligent Acts-Patient S.M.G.)**  
**(Bus. & Prof. Code § 2234(c))**

106. Complainant realleges paragraphs 101-105 above, and incorporates them by reference as if fully set forth herein.

107. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that:

a. Respondent's false documentation that S.M.G.'s vaginal cultures were sent for laboratory analysis is a departure from the standard of care. If Respondent cancelled such an order, his records should reflect such a cancellation. S.M.G. was told cultures were sent, and to return for results.

b. Respondent's diagnosis of "bacterial vaginosis" in S.M.G. was incorrect, and is a departure from the standard of care. Such a diagnosis requires 3 out of the 4 following findings: homogenous, thin, white discharge that smoothly coats the vaginal walls; presence of clue cells on microscopic examination; pH of vaginal fluids greater than 4.5; and/or a fish odor before or after adding potassium hydroxide solution to vaginal discharge. Respondent failed to perform a pelvic examination or analyze the vaginal discharge, and thus a diagnosis of "bacterial vaginosis" was impossible.

c. Respondent's failure to complete a pelvic examination is a departure from the standard of care.

d. Respondent's failure to appropriately treat S.M.G. for possible gonorrhea is a departure from the standard of care.

e. Respondent's failure to generate a medical record for S.M.G. on May 30, 2014, is a departure from the standard of care. It is not necessary to generate a medical record for a patient who is merely picking up lab results; however, having placed S.M.G. in an exam room and having her wait, Respondent should have generated a medical record reflecting his intention to discuss lab results and provide a consultation.

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**TWENTY-EIGHTH CAUSE FOR DISCIPLINE**  
**(General Unprofessional Conduct – Patient S.M.G.)**  
**(Bus. & Prof. Code § 2234)**

108. Complainant realleges paragraphs 101 - 107 above, and incorporates them by reference as if fully set forth herein.

109. Respondent is subject to disciplinary action under Code section 2234 in that, on or about May 30, 2014, he raised his voice at patient S.M.G. and humiliated her in front of other patients. Respondent's conduct constitutes unprofessional conduct within the meaning of Code section 2234.

**TWENTY-NINTH CAUSE FOR DISCIPLINE**  
**(Gross Negligence -Patient M.T.)**  
**(Bus. & Prof. Code § 2234(b))**

110. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he is guilty of gross negligence relative to his care and treatment of patient M.T. The circumstances are as follows:

111. On or about June 17, 2012, Patient M.T. was 36 years-old when he presented to Impact Medical with a complaint of a bee sting to his hand. The patient's vital signs were taken by a medical assistant. Respondent documented "Right hand bee sting 9 pm last night," noted "hand swollen," and drew a picture of a hand with a dot in the middle. Respondent's assessment was "Right Hand Abscess, Cellulitis, and Bee Sting." Respondent's treatment was incision and drainage, stitches, Rocephin 1 mg IM (intramuscular injection), Benadryl 50 mg IM, and Kenalog 60 mg IM. Respondent billed M.T. for laceration surgery, incision and drainage, and simple repair of wound to scalp.

112. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he performed an incision and drainage given a complaint and diagnosis of bee sting. A bee sting is an anaphylactic chemical allergic reaction, treated with antihistamines and occasionally steroids. Incision and drainage is absolutely contraindicated. Local swelling caused by bee sting is not a wound or abscess with pus that requires drainage. Cutting into the swollen area exposes the patient to infection and a worse reaction. Respondent's treatment of a bee sting with incision and drainage is an extreme departure from the standard of care.

1 113. Respondent is subject to disciplinary action under Code section 2234, subdivision (b),  
2 in that he failed to document a procedural note including a description of the procedure, what  
3 materials were used for packing or suturing, what came out of the drainage wound, and the  
4 patient's tolerance of the procedure. Respondent's failure to document a procedural note is an  
5 extreme departure from the standard of care.

6 114. Respondent is subject to disciplinary action under Code section 2234, subdivision (b),  
7 in that he sutured a wound which he described as an abscess. An abscess that requires incision  
8 and drainage should never be sutured, as an abscess has pus, and suturing pus makes an infection  
9 worse. Incision and drainage is always left open and usually requires packing to allow healing  
10 from the inside out. Respondent's documentation of having sutured an abscess is an extreme  
11 departure from the standard of care.

12 **THIRTIETH CAUSE FOR DISCIPLINE**  
13 **(Repeated Negligent Acts-Patient M.T.)**  
14 **(Bus. & Prof. Code § 2234(c))**

15 115. Complainant realleges paragraphs 110 - 114 above, and incorporates them by  
16 reference as if fully set forth herein.

17 116. Respondent is subject to disciplinary action under Code section 2234, subdivision (c),  
18 in that:

- 19 a. Respondent's performance of an incision and drainage to treat a bee sting is a  
20 departure from the standard of care;  
21 b. Respondent's failure to document a procedural note is a departure from the  
22 standard of care; and  
23 c. Respondent's suturing of what he believed to be an abscess is a departure from  
24 the standard of care.

25 **THIRTY-FIRST CAUSE FOR DISCIPLINE**  
26 **(Failure to Maintain Patient Records-patient M.T.)**  
27 **(Bus. & Prof. Code § 2266)**

28 117. Respondent is subject to disciplinary action under Code section 2266 in that he is  
guilty of failure to produce and maintain an adequate and accurate record of his treatment of  
patient M.T. The circumstances are as follows:

1 118. Complainant realleges paragraphs 110 – 116 above, and incorporates them by  
2 reference as if fully set forth. Respondent is subject to disciplinary action under Code section  
3 2266 in that he failed to document a procedural note for patient M.T.

4 **THIRTY-SECOND CAUSE FOR DISCIPLINE**

5 (Dishonesty - Patient M.T.)  
6 (Bus. & Prof. Code § 2234(e))

7 119. Respondent is subject to disciplinary action under Code section 2234, subdivision (e),  
8 in that Respondent billed M.T.'s medical insurance for services not rendered. The  
9 circumstances are as follows:

10 120. Complainant realleges paragraphs 110 - 118 above, and incorporates them by  
11 reference as if fully set forth herein.

12 121. M.T.'s insurance was billed for two lacerations that were not present. The first  
13 laceration is for scalp wound repair that was allegedly done on the same day that he presented  
14 with the bee sting. M.T. had no injury to his head, and there is no medical documentation of a  
15 wound to M.T.'s head. The second laceration was an "intermediate laceration" to the hand. This  
16 too is a fraudulent charge because the incision and drainage caused the opening, and is not a  
17 laceration. Furthermore, the size and depth of the laceration was not "intermediate," as this term  
18 means longer than a simple layer closure.

19 122. Respondent's conduct of billing M.T.'s insurance for services not rendered  
20 constitutes dishonesty within the meaning of Code section 2234, subdivision (e).

21 **THIRTY-THIRD CAUSE FOR DISCIPLINE**

22 (Gross Negligence -Patient V.R.)  
23 (Bus. & Prof. Code § 2234(b))

24 123. Respondent is subject to disciplinary action under Code section 2234, subdivision (b),  
25 in that he is guilty of gross negligence relative to his care and treatment of patient V.R. The  
26 circumstances are as follows:

27 124. On or about January 20, 2014, Patient V.R. was 38 years-old when she presented at  
28 Impact Medical with a complaint of shoulder pain and cough. She was seen by another  
physician, who ordered an x-ray, and prescribed Vicodin for pain and amoxicillin for bronchitis.  
V.R. was told to return for her x-ray results.

1 125. On or about January 22, 2014, Patient V.R. underwent an x-ray, and was given the  
2 results on a compact disc (CD) to take to her physician. She returned to Respondent's clinic with  
3 the CD, and was placed in an exam room, where she waited approximately two hours.  
4 Eventually, she was seen by Respondent, who indicated that he did not have the equipment to  
5 read "MRIs." V.R. indicated that the CD contained plain x-rays, not an MRI. Respondent told  
6 V.R. she could return to the lobby so that he could review the CD. V.R. asked Respondent to  
7 review the CD then and there, since she had been waiting for two hours. Respondent and V.R.  
8 argued in the lobby in front of other patients, and then Respondent told V.R. to leave, telling the  
9 receptionist to call the police if V.R. didn't leave. Respondent said he would put V.R. on a list of  
10 patients who could no longer receive care at his facility.

11 126. The following day, V.R. called Respondent's clinic asking for information about the  
12 prescriptions she had received, and was told that, per Respondent's order, they could no longer  
13 provide her any assistance. V.R. returned to the clinic to obtain a copy of her medical records.  
14 Upon her return, she was seen by the original physician whom she had seen on her first visit, who  
15 apologized for Respondent's behavior and reviewed V.R.'s x-ray results, and provided her with a  
16 referral.

17 127. Respondent is subject to disciplinary action under Code section 2234, subdivision (b),  
18 in that he refused to review V.R.'s x-ray results. Respondent neither reviewed the x-rays himself  
19 nor reviewed any radiologist report. Respondent's failure to review the results of an x-ray  
20 ordered by another physician at his clinic is an extreme departure from the standard of care.

21 **THIRTY-FOURTH CAUSE FOR DISCIPLINE**

22 (Dishonesty - Patient V.R.)  
23 (Bus. & Prof. Code § 2234(e))

24 128. Respondent is subject to disciplinary action under Code section 2234, subdivision (e),  
25 in that Respondent billed V.R.'s medical insurance for services not rendered. The circumstances  
26 are as follows:

27 129. Complainant realleges paragraphs 123 - 127 above, and incorporates them by  
28 reference as if fully set forth herein.

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1 130. V.R.'s insurance was billed for a detailed office visit for January 22, 2014. The  
2 medical records reflect a pulse oximetry reading was taken, but no other vitals, no physical exam,  
3 no counseling, no review of V.R.'s x-ray, and no care. There was no detailed office visit.

4 131. Respondent's conduct of billing V.R.'s insurance for services not rendered constitutes  
5 dishonesty within the meaning of Code section 2234, subdivision (e).

6 **THIRTY-FIFTH CAUSE FOR DISCIPLINE**  
7 **(General Unprofessional Conduct – Patient V.R.)**  
8 **(Bus. & Prof. Code § 2234)**

9 132. Complainant realleges paragraphs 123 - 131 above, and incorporates them by  
10 reference as if fully set forth herein.

11 133. Respondent is subject to disciplinary action under Code section 2234 in that, on or  
12 about January 22, 2014, he raised his voice at patient V.R. and humiliated her in front of other  
13 patients. Respondent's conduct constitutes unprofessional conduct within the meaning of Code  
14 section 2234.

15 **THIRTY-SIXTH CAUSE FOR DISCIPLINE**  
16 **(Dishonesty - Patient B.H.)**  
17 **(Bus. & Prof. Code § 2234(e))**

18 134. Respondent is subject to disciplinary action under Code section 2234, subdivision (e),  
19 in that Respondent billed B.H.'s medical insurance for services not rendered. The circumstances  
20 are as follows:

21 135. On or about August 9, 2014, Patient B.H. was 57 years-old when she presented to  
22 Impact Medical for follow-up regarding a swollen, twisted ankle. B.H. was seen by a nurse  
23 practitioner. The chief complaint was documented as "Came to read MRI results. Ankle still  
24 swollen/pain." Vital signs were not documented at all. A physical examination of the head, neck  
25 and throat, lungs and chest was documented, but there is no documentation of an examination of  
26 the ankle. Assessment was documented as "MRI result reviewed." Treatment was to control  
27 pain, increase ice, and surgical boot. B.H. was billed for both a detailed office visit, and for a  
28 follow-up visit. There was no detailed office visit.

136. Respondent's conduct of billing B.H.'s insurance for services not rendered constitutes  
dishonesty within the meaning of Code section 2234, subdivision (e).

1                                    **THIRTY-SEVENTH CAUSE FOR DISCIPLINE**

2                                    **(Excessive Treatment/Prescribing)**

3                                    **(Bus. & Prof. Code § 725)**

4                    137. Complainant realleges paragraphs 11-30 and 37-57 above, and incorporates them by  
5 reference as if fully set forth herein.

6                    138. Respondent is subject to disciplinary action under Code section 725 in that he is  
7 guilty of repeated acts of excessive treatment relative to his care and treatment of patients S.C.  
8 and S.G.. The circumstances are as follows:

9                    a.     Respondent administered to patient S.C. 4 liters of fluid over a three-hour  
10 window without medical justification.

11                   b.     Respondent administered to patient S.G. 2 liters of fluid over a three-hour  
12 period, which is seven times the recommended fluid dose for pediatric patients.

13                                    **THIRTY-EIGHTH CAUSE FOR DISCIPLINE**

14                                    **(Dishonesty)**

15                                    **(Bus. & Prof. Code § 2234(e))**

16                    139. Respondent is subject to disciplinary action under Code section 2234, subdivision (e)  
17 in that he misrepresented the required fees that his patients must pay for services received at  
18 Impact Medical and rarely reimbursed patients; Respondent commonly diagnosed patients with  
19 dehydration and unnecessarily administered IV fluids and the antibiotic Rocephin and charged  
20 excessive amounts for such services; Respondent had a pattern or practice of fraudulently creating  
21 patient records; and Respondent was not honest with Medical Board Investigators. The  
22 circumstances are as follows:

23                    140. Complainant realleges paragraphs 11-30, 37-57, and 85-90, above, and incorporates  
24 them by reference as if fully set forth herein.

25                    141. Respondent instructed his staff to bill all patients the urgent care fee of \$50.00 and to  
26 inform patients that if their insurance paid their bill, then the office would reimburse or refund  
27 their money. Respondent rarely reimbursed patients.

28                    142. Respondent commonly diagnosed patients with dehydration and administered IV  
fluids and the antibiotic Rocephin. The Rocephin cost Respondent \$0.50 per unit, but  
Respondent charged \$99.00 per injection. Respondent would ask patients how much they could

1 pay and then billed them accordingly. Respondent charged patients \$800.00 to \$1,400.00 per unit  
2 of saline IV fluids.

3 143. Respondent had a pattern or practice of completing patient IV logs after the fact, as  
4 well as pulling patient charts after denial of payment and changing chart notes to accommodate  
5 the billing.

6 144. Respondent was not honest with Medical Board investigators when he represented  
7 himself as an "intensivist." Respondent's credentials do not qualify him as an intensivist.

8 145. Respondent was not honest with Medical Board investigators when he said that he did  
9 not have any previous disciplinary issues with his medical license. Respondent's Tennessee  
10 license was denied reinstatement due to a finding that he had engaged in "unprofessional,  
11 dishonorable or unethical conduct; and making false statements or representations, being guilty of  
12 fraud or deceit in obtaining admission to practice, or being guilty of fraud or deceit in the practice  
13 of medicine."

14 146. Respondent was not honest with Medical Board investigators when he said that the  
15 mother of patient S.G. voluntarily paid the 20% bill because she was given the option to wait until  
16 the insurance company had been billed.

17 147. Respondent's conduct constitutes dishonest acts within the meaning of Code section  
18 2234, subdivision (e).

19 **PRAYER**

20 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,  
21 and that following the hearing, the Medical Board of California issue a decision:

22 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 43177,  
23 issued to Ifeatu Ekelem, M.D.;

24 2. Revoking, suspending or denying approval of Ifeatu Ekelem, M.D.'s authority to  
25 supervise physician assistants, pursuant to section 3527 of the Code;


26 3. Ordering Ifeatu Ekelem, M.D. to pay the Medical Board of California the costs of  
27 probation monitoring, if placed on probation; and

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1           4     Taking such other and further action as deemed necessary and proper.

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DATED: March 1, 2017

  
KIMBERLY KIRCHMEYER  
Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
*Complainant*

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